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DIAGNOSIS AND TREATMENT OF ECTOPIC GESTATION.*

(Abstract.)

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I accept the usual classification of ectopic pregnancy, that is, tubal, tubo-ovarian, and tubo-uterine. It is very questionable if an overian variety ever occurs. Certainly it must be a very rare condition. Some years ago the late Dr. James E. Reeves pronounced the specimen from a case operated on by me one of probable ovarian pregnancy. The patient was referred to me by Dr. Hayes, of Union Springs. The cases which have been pronounced abdominal pregnancy are due to a secondary process, the placenta remaining attached to the tube and adjacent structures.

For the purpose of this paper the pathology of tubal pregnancy only need be kept in mind.

The condition was regarded very rare until within the last few years. Now every abdominal surgeon meets some cases in the course of a year's work. The cases of hematocele and hematoma recognized before ectopic gestation was shown to be the principal cause of their production prove

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that it was the failure of the profession to recognize the condition rather than its absence.

DIAGNOSIS PRIOR TO RUPTURE

The symptoms of pregnancy in connection with a "deviation from normal menstruation" should suggest this condition. There is usually a history of the last period having been scant or delayed for some days or weeks; then the flow appeared unnaturally and there was a constant dribble which kept up for some time. Such symptoms, particularly if occurring in a woman who has been sterile for some years, should lead to an investigation of the pelvic organs. If on examination the uterus is found somewhat enlarged, the cervix soft as in pregnancy, and a small mass on the side or behind the uterus, very vascular as shown by the throbbing sensation conveyed to the examining finger, the diagnosis of tubal-pregnancy is quite presumptive. If the history of the pelvic organs should show that there was no enlargement of the tube or other growth in the pelvis until within a few weeks it is almost a certainty that the diagnosis is correct.

The following conditions must be excluded from tubal pregnancy—uterine gestation, hydrosalpinx, hematosalpinix, pyosalpinx, uterine fibroids and small ovarian tumors. In all cases the possibility of the mass behind or on the side of the uterus being fecal should be excluded by emptying the intestines and the introduction of the finger into the rectum. At this time the uterus has not as a rule discharged a portion of the decidua and the cervix should be slightly dilated, instrumentally, and a small currett used to remove a part of the membrane. It is safer to take the chance of producing an abortion by intra-uterine examination than to allow the case to progress with so much danger confronting the patient. The absence of chorionic villi will demonstrate that the pregnancy is extra-uterine. In some cases it would be advisable to resort to operation for the removal of the extra-uterine mass regardless of diagnosis. Hydrosalpinx is as a rule bilateral and the physical examination reveals a thinner walled and less vascular mass than tubal pregnancy. The history of the case will show that the hydrosalpinx has existed for some time and the symptoms of pregnancy are absent. Hematosalpinx furnishes physical signs very similar to tubal pregnancy, but there is absent the symptoms of pregnancy, and the history of the case is different. Pyosalpinx gives the history of pelvic inflammation, elevation of temperature, etc. Physical examination reveals a harder mass with less vascularity than is found in tubal pregnancy. A fibroid is intimately attached to the uterus and much harder than the pregnant tube.

It may be associated with tubal pregnancy and then the case presents obvious difficulties in diagnosis. Ovarian tumors are different in

shape and symptoms and signs of pregnansy are absent. Small ovarian dermoids are often overlooked until uterine pregnancy occurs and then the case presents many difficulties.

From the above remarks on differential diagnosis the lesson is very clear that cases should be more carefully watched and a thorough pelvic examination made when symptoms arise pointing to trouble in that locality. Of course there is a good deal more probability of no local trouble being made out where there is pain than of there being a mass in the pelvis without causing some disturbance. There will be some unnecessary examinations, but this is essential to insure an early diagnosis. Every case should have a physical examination when the symptoms point to pregnancy, so as to determine the exact condition of the uterus and its adnexa, as well as other pelvic conditions. Many complications in uterine pregnancy occur that should be avoided by the physician possessing the knowledge which would be acquired in this way. It is to the general practitioner that we must look for this advance—and I use the term advance advisedly; for in the past a diagnosis before rupture has seldom been made. The exceptions have occurred when the gynecologist was consulted prior to rupture for pain in the pelvis, and the uterus was found enlarged, the cervix soft and a mass, such as I have described, on the side or behind the uterus. Abdominal surgeons see but few cases before rupture and until recently, it was generally taught by them that the diagnosis could be only very exceptionally made prior to this accident. The treatment is so devoid of danger before the rupture and so great later that too much importance can not be attached to this phase of my subject.

DIAGNOSIS AT TIME OF RUPTURE.

If into the general cavity, the patient suffers from severe pain in the pelvis, which may cause her to become unconscious. There are the symptoms of internal hemorrage, such as nausea, cold prespiration, fast pulse, and subnormal temperature. On examination there is no distinct tumor but there is the sensation of fluid or an indistinct doughy feel. Should the rupture occur into the folds of the broad ligaments, and this is extremely rare, the signs of pelvic hematoma are present—that is a well defined tumor on the side of the pelvis pushing the uterus to the opposite side.

DIAGNOSIS AFTER RUPTURE OF THE TUBE.

The physical signs of Ectopic pregnancy after rupture are the same as those of pelvic hematocele and pelvic hematoma. There is expulsion of uterine decidua about the time of rupture "in shreds or entire." It resembles the dicidua of normal pregnancy and the membrane of membranous dysmenorrhea. It differs from the membrane of normal preg-

nancy in the absence of chorionic villi and is smooth on the inside. It differs from the membrane of dysmenorrhoea in the presence of large cells in the decidua vera, and the recurrence of membranous dysmenorrhoea. In order to differentiate from a pyosalpinx rupture it must be remembered that in ectopic pregnancy "the pulse is more frequent, temperature subnormal, pain of short duration and the loss of blood evident." While in pyosalpinx septic symptoms are present or will soon develop and the temperature rises steadily and the pain is of longer duration. If septic symptoms develop in ectopic pregnancy it occurs later, some days or weeks after the rupture. There are exceptions to this rule and the blood examinations may be misleading. Less than a year ago I saw such a case. Mrs. A. was taken suddenly ill with very great pain after some departure from normal menstruation. The physician thought of ectopic gestation but the blood showed marked leucocytosis and the temperature remained above normal, the pulse gradually going up till the operation some twelve hours after the rupture. The patient had suffered from salpingitis, the uterus was retrodisplaced and adherent. So, notwithstanding many of the evidences of ectopic gestation, peritonitis was thought of and looked for. Of course the aberrent symptoms were due to the mixed nature of the case. The operation was followed by complete recovery.

The differential diagnosis between a collection of blood due to ectopic gestation and a pelvic abscess is sometimes attended with marked difficulty. When infection has not occurred the diagnosis is easy. The patient gives the history of ectopic pregnancy with rupture some days or weeks previously, and the physical signs reveal a tumor behind and partly surrounding the uterus. The temperature is normal or very near normal. In an abscess there would be the symptoms of sepsis with elevation of temperature and the mass in the pelvix would have a thicker wall. Seven years ago I operated on a case for pelvic abscess in which all the signs and symptoms I have described were present, but it was before I had become so impressed with the importance of the absence of temperature in the diagnosis of ectopic gestation.

Cases in which infection occurs give rise to the symptoms and signs of a pelvic abscess. The history of the case will often enable one to make a correct diagnosis. Recently I was called to see a young woman who had been married three years. She had one child two years old, and ten months ago had given birth to an eight month child, which lived twenty-four hours. She had always suffered slight pain in the right inguinal region. Her monthly sickness was regular after the birth of the premature child, except that it was always a few days late. She menstruated on the 27th of August and again on October the 6th, missing a few days longer than usual. About the 20th of October, while out shop-

ping, she was taken with severe pain in the pelvis and had to sit down. She soon recovered and was able to walk home. She began to have a flow which was scant and dark colored. On November 4th, at night, she was taken with very violent pain and had to have a hypodermic of morphine before being relieved. The flow came on quite profusely. There was no elevation of temperature for some days, but after the 11th or 12th of November she began to have fever, and the temperature would run as high as 101 or 102 in the afternoon. I saw her on the morning of the 17th with Dr. Sholl, her physician. I found high up on the right side a mass which could not be very well defined. Was not positive of diagnosis but advised vaginal section. The operation revealed large quantities of black blood clots and adhesions behind especially on the right side of the uterus. The patient's temperature began going down at once and since the operation has been scarcely above normal. The womb was swabbed out at the time of the operation. The flow has not disappeared but is gradually growing less. This case presents the difficulties of diagnosis where sepsis has occurred. It was also more difficult from the fact that the tumor was on the right side, while in ectopic pregnancy it is usually in the cul-de-sac.

TREATMENT.

Prior to rupture abdominal section should be advised and the tube with its contents removed. Such an operation is attended with almost no mortality, and is one of the simplest in the Surgery of the abdomen. Seven years ago Dr. Bogart, Professor of Gynecology in the Chattanooga Medical College, referred a case to me for operation in which he had made the diagnosis of tubal gestation, the patient having had a severe attack of pain with a history of the early symptoms of pregnancy. On examination I found a vascular mass on the side of the uterus. At the operation the tube was in tact, and the speciman a most excellent illustration of the pathology of tubal gestation prior to rupture. The pain was due to a threatened rupture and the operation prevented what would very soon have placed the woman's life in jeopardy. I received a letter recently from her husband saying that her health was good. Electricity should not be advised, and the injection of morphine and other agents into the gestation sack cannot be too severely condemned. Electricity has very few advocates now, but ten or twelve years ago quite a goodly number of able men recommended it prior to a rupture. It may, of course, succeed but its use is attended with more danger than an operation by a competent surgeon. Eleven years ago I restored to electricity in such a case and the patient soon developed severe septic symptoms and for many weeks her condition was very critical. She ultimately recovered, but it is needless to say that my faith in electricity for this condition was shaken.

After rupture (Intraperitoneal), if the pulse is improving and other symptoms point to the patient's getting better it is advisable to defer operation till the shock is recovered from. Preparations, however, should be begun at once for the operation.

The abdomen should be gently shaved and a moist bichloride of mercury dressing applied. In these operations the slow and hesitating surgeon fails. The abdomen must be quickly opened and the tube at once seized and ligated. The blood clots may then be turned out. It is advisable to flush with salt solution and drain, also to inject three or four pints of the salt solution under the breasts, beginning as soon as the tube has been secured. Before this, nothing could be more dangerous as it would only favor bleeding. In 1893, I lost a case, Mrs. B. by taking the time to turn out the clots, before securing the bleeding tube. Perhaps the patient might still have been saved by proper after treatment, but at this time the infusion of salt solution was not generally practiced. Patients apparently dying may often be saved by recourse to this treatment. Ten years ago I operated on a fatal case for Dr. Camp at Gadsden, several days after the rupture; and while the patient's pulse was quite fast before the operation, after the tube had been removed and the patient put to bed the pulse was much better than in many of the cases which recover now after hypodermoclysis.

In these cases where a pus tube or pus tube complicated by a pelvic abscess is associated with tubal pregnancy on the opposite side, or a suppurating dermoid complicates the ectopic pregnancy, operative difficulties are marked and tax the surgeon in the extreme. I operated on such a case for Drs. McLaughlin and Ash of St. Clair Co. seven years ago in which I removed a five month foetus, and a tube-ovarian abscess. There were many adhesions and as a result a large raw area to be drained. I have never been taxed more in any operation. I presented specimens from this case a few days after the operation at the meeting of the Alabama Medical Association. The recovery of the patient was slow and her dife was almost despaired of for a time. She is now in good health. When I first examined the woman I thought it was probably a case of uterine pregnancy with pelvic complications and examined and re-examined the patient trying to exclude uterine pregnancy. Dr. Ash insisted that this was impossible and I could not understand why he could be so positive, when he laughingly told me he had been swabbing out the uterus several weeks.

If the patient's condition is so extreme that the experienced surgeon is almost certain that death would result from an operation, then there is nothing to do but to wait with the hope of the case rallying from the shock. In the latter part of November of last year I saw such a case with Dr. E. S. Jones, of Gadsden, twenty-four hours after the rupture.

The pulse was so feeble and fast and the patient's condition so extreme I waited twenty-four hours and by so doing I had an opportunity of doing the operation when the pulse was fairly good. The patient's life was saved.

Would only advise vaginal operation in septic cases where there is a thick wall around the collection. The foetus as a rule dies after the first rupture.

After rupture (extra-peritoneal) the patient may be watched and the collection will probably be absorbed. If suppuration should occur incise by the vagina.

If the foetal life should continue to full term, remove placenta if not extensively attached, otherwise leave and treat aseptically. Cases should seldom be allowed to go to term.

In conclusion I desire to emphasize the importance of securing tube as soon as the abdomen is opened, and beginning the injection of salt solution under the breasts when this has been accomplished. Atropine should be given hypodermically to warm the patient and control the profuse sweating.

CHRONIC HYPERTROPHIC RHINITIS.*

By Dr. C. H. Franklin,

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By the term Hypertrophic Rhinitis we mean a chronic productive inflammation of the nasal mucous membrane, resulting in an increase of the various cells entering into the formation of this membrane with its consequent more or less occlusion of the nasal chambers.

This hypertrophy is usually permanent, though I believe many of the atrophic catarrhs have as their beginning a hypertrophic form and the atrophy is simply the final stage of the inflammatory process. Why they should not all reach this final stage I do not know. We know that other organs, as the liver for instance, may be the seat of either form of inflammation without necessarily passing through both stages.

As the cause of this form of rhinitis we may say, that any abnormal anatomical condition or irritant which, by its presence causes a hyperemic condition of the mucosa, will through its attendant increase in nutrition produce the trouble. As a result of this increased nutrition the cellular elements of the tissue undergo a true hyperplasia. This process is necessarily slow and I believe most of the cases have their beginning in childhood.

The anatomical abnormal conditions causing the trouble are de-

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flected septa, enlarged tonsils, spurs, adenoid growths, and enlargement of the turbinated bodies, probably the most important one being deviations of the septum. Of two thousand examinations, of the nose and throat, made by Chappell, of New York, the subjects all being children, twelve hundred and thirty-one were found to be suffering from some one of the above mentioned conditions, so that we are not astonished at the large number of chronic hypertrophic rhinitis cases which are in existence.

Of the irritants causing the disease I believe that a dust laden atmosphere to be the most important, and I am not sure but that this plays a more important part as an exciting cause than any other one agent. The atmosphere of this country is notoriously dusty and the fine particles are deposited on the mucous membrane by the inspired air; there finding lodgment and by their mechanical irritation, long continued, producing a hyperemic condition of the mucous membrane.

Other causes have been ascribed as, tobacco smoke, climatic changes, "catching cold," injuries and constitutional disorders, the rheumatic, gouty, syphilitic or tubercular diathesis. Catching cold I believe to be more often a result than a cause. The others require question marks of varying distinctness to be placed after each.

The pathological condition has already been touched upon and consists in an increase of the connective tissue and the glandular elements. The new glandular structure, probably from pressure, does not perform its proper functions and there is not as ordinarily supposed an increase in secretion. The epithelial cells covering the mucosa are increased in number. The blood vessels are surrounded by a thick connective tissue frame work, and the veins are large, numerous, and filled with stagnated blood. The glands, as has already been stated, are more numerous, though the new ones are devoid of function. The whole process is therefore a productive inflammation. The symptoms are more or less pronounced. I have seen cases where no symptoms were complained of. Where subjective symptoms are present probably the most frequent is obstruction to respiration, impaired smell or voice. Others complain of great ease in catching cold, a dry hacking cough generally due to mouth breathing, or a dropping of secretion into the pharynx. There are also, sometimes certain eye, ear, or nervous troubles, as neuralgia, or headaches which may be traced to the nose for their cause.

The diagnosis is made upon examination. The mucous membrane is found swollen and red. The nostrils more or less occluded, and the turbinate bodies bulging and tumor like, either anteriorly or posteriorly. The application of cocaine causes only a partial contraction of the tissues.

The treatment to be efficient must necessarily be surgical. Sprays in advanced cases, other than for their cleansing effect, I believe to be of

small value. It cannot be hoped to restore the mucous membrane to its normal condition and our efforts must be directed toward removing a sufficiency of the hypertrophied tissue to restore nasal breathing, trusting that there may be left enough of the normal mucous membrane to carry on its proper functions. Here as in all other diseases the cause if possible should be removed, hence deflected septa should be straightened, spurs removed and the normal anatomical condition restored as nearly as possible. With the best of treatment the condition is likely to return. In the earlier stages cleansing followed by astringent sprays may be sufficient. As a cleansing spray Dobells solution is probably as good as any. As astringent sprays I have used principally the silver nitrate and zinc sulphocarbonate solutions, varying in strength from two to ten grains to the ounce of water.

Where there is nasal obstruction it is necessary to remove enough tissue to allow of free nasal respiration. This may be done by cutting instruments or caustics, either thermal or chemical. Of the chemical agents the most frequently used are nitric, chromic or trichloracetic acid. The nitric and trichloracetic acid may be applied by means of a cotton tipped probe to the diseased area. The chromic acid must be fused on to the end of a probe before applying. It is first necessary to first cocainize the mucous membrane before making the application. The galvano-cautery is preferred by many. Where the posterior ends of the turbinals are enlarged, it is best to remove the superfluous tissue by means of a snare. In this latter operation do not cocainize the tissue to be removed, for if cocainized it will contract and the snare cannot be made to surround it.

Before any operative procedure the nose should be cleansed, and the operation followed by a mild oleagenous and antiseptic spray.

I notice that Kyle prefers to remove a wedge shaped piece of tissue from the enlargement by means of a knife, allowing the wound to close so that a linear scar remains, parallel to the turbinal body.

As the object is to relieve the obstruction with as little loss of mucous membrane as possible it seems to me that the method of subcutaneous cauterization, as done by Pierce, of Chicago, or the method by electrolysis should be productive of good results.

BURNS OF THE SKIN; THEIR PATHOLOGY AND REPAIR.*

By G. S. Brown, M. D.

While I have no doubt this whole subject has been very much better presented elsewhere it has been my ill fortune not to be able to find very much upon it in any of the surgical text books, so that a good part of this paper is based on observations from personal experience and upon deductions drawn from a consideration of the surgical principles necessarily concerned. While practically we are in the habit of regarding burns as superficial and deep and find this simple classification all sufficient, as a rule, in determining a line of treatmnt, still a study of the old classification of Dupuytren will aid materially in an understanding of the pathology; and pathology in burns, as in every other branch of medicine, is a long step toward final causes and helps to arrange our medical knowledge into something like orderly sequence.

The skin has been defined as "A complex elastic organ which completely invests the body, being continuous at all the natural orifices with the mucous membrane or inner skin and through its own deep connective tissue with the underlying structures throughout."

The skin consists of, (a) Stratum Corneum, or horny layer with its two skin consists of, (a) the Stratum Corneum, or horny layer with its two parts, superficial and deep. (b) Stratum Lucidum, a narrow translucent streak; (c) Stratum Granulosum; (d) Stratum Mucosum or Rete Malpighii which is the deepest of the epthelial layers and lies directly upon, and is inseparably attached to, the Corium by means of the epithelial prolongations which it sends down betwween the papillae of the corium. The skin then consists of two parts, a superficial, or epidermic derived, from the epiblast and a deep (the Corium, Derma or true skin) which is connective tissue developed from the mesoblast.

The Corium varies from one to one and a half lines in thickness being from five to ten times the thickness of the epithelial layer.

The Rete Mucosum is made of living cells of protoplasm which are bound together by fine prolongations from each to each which have given them the name of prickle cells. Between these cells there is a system of channels by which the epithelium is nourished. According to Kolliker, Ranvier and others the roundish granules which give the next layer its name of stratum granulosum consist of Eleidin or Kerato-hyalin a substance essential to the process of cornification in the elements making up the horney layer of the skin and nails! Some of these granules can be seen in the more superficial of the prickle layer but they belong more especially to the Stratum granulosum.

"In the Stratum Lucidum the cells have suddenly lost the refractive shining granules of Kerato-Hyalin; they are supposed to have disappeared in consequence of their solution in the protoplasm of the cell body which has thus acquired an added brilliancy and clearness."

*Read before the Jefferson County Medical Society.

The outermost or horny layer are flattened lifeless cells which can be traced nevertheless to their birth place in the prickle layer or Rete Mucosum; by the birth of new cells below they have been gradually crowded to the surface. According to the classification of Dupuytren in burns of the First Degree—there is a slight redness of the skin and a few patches of the horny layer may be thrown off. In burns of the Second Degree there is increased redness with swelling and an effusion of serum takes place here and there which lifts up the entire horny layer into blebs. In this degree burns are more painful than in any other, this being due principally to the sudden swelling of the Rete and pressure upon the sensory end organs of the papillae. A burn of this degree of course leaves an epithelial surface which quickly glazes over and gets well in a few days leaving a pigmented area perhaps which lasts a few weeks but does not leave a scar.

"Burns of the Third Degree" destroy all the epithelium and the papillary layer of the corium; these are destroyed together because the papillae and the downward projections of the Rete are inseparable. This third degree then results in a total destruction of all epithelium covering the part, together with all epithelial function, such as, the secretion and excretion by the glands, the growth of hair, etc. The true skin, however, is left hence there is no contracting scar, but the true skin is quickly covered over with a thin fibrous scar which breaks down easily and often gives a great deal of trouble before it is finally healed.

"Burns of the Fourth Degree" destroy the entire thickness of the skin, the result being a growth of white inelastic scar tissue which contracts and, according to the seat of the injury, results in greater or less deformity.

The Fifth and Sixth Degrees of Burns according to the classification of Dupuytren affect the muscles and bones and hence are beyond the scope of the subject of this paper. This short resumé of the histology of the skin shows that the behavior of burn wounds depends almost wholly upon the depth of the destruction and, in the same way, it must also show the absurdity of the claims (that are all too common) that certain medicinal applications will cause new skin to grow where there is nothing for it to grow from, and will prevent contracting scars.

This review shows also, I think, the epithelial grafts (Theirsch) cannot wholly take the place of the skin, though they almost entirely prevent contractions, they afford very little protection to the parts beneath and are often tender and adherent for a long time. The ideal method for the repair of skin defects particularly in parts where it is desired to avoid all contraction, is, of course, transplantation. A great deal has been written about transplantation and all the writers without an ex-

ception, seem forever wedded to the undetached flap method. I will here report my brief experience in this line:

Miss H. aet. 16. About sixteen months ago had her hand caught in an ironing machine and sustained a combined crush and burn of the hand and the result was, after a period of eight months of healing by granulation, a badly contracted scar on the back of the hand and a much worse one on the palm. This last resulted in a dense cicatrix of the palm which drew the thenar and hypothenar eminences together and caused a contraction of the thumb and all the fingers into the palm where they were almost fixed. Upon dissection this scar was found to involve all the skin, fascia and tendon sheathes of the palm. When this scar was removed and the skin and tendons dissected free at the base of each finger and then spread out, there was a defect, oval in shape, about two or three inches in size, with a base of the metacarpal bones thinly covered by the tendon sheathes and periosteum. It seemed probable that a Theirsch graft in such a deep wound would not prove satisfactory, so I took from the thigh a free flap, the full thickness of the skin and full large so that it would cover the defect without tension, and stitched it in place with silk. A compress was applied which kept the flap firmly in contact with the underlying structures and the result was it at once took up its blood supply, having not suffered at all from the temporary anemia, in fact it did not even lose its superficial horny layer as the Theirsch grafts always do.

Although the authorities seem incurably wedded to the undetached-flap method of skin transplantation, I was led to do this free flap operation with a good deal of confidence by the following considerations: In the first place I had had several accidents of this kind and I had learned that the skin being torn from its attachments will nearly always live when replaced, if the precaution is taken to make openings in it for drainage, that the flap may not be dissected up by the fluids and separated from its underlying muscle against which it should lie close compressed. If it should be so dissected up it will die no matter how broad an attachment it may have to the healthy skin. This surgical fact is also suggested by the histology. It will be seen that the skin derives its blood supply from the part directly beneath and that practically its blood vessels run only vertically; as, in other words, there can be no blood supply from one part of the skin to another to amount to anything, there is not much logic in expecting to secure nourishment through a skin pedicle.

Finally this case proves that it is not at all essential. This flap united primarily which is a thing impossible of attainment when the flap is left attached. The treatment suggested therefore by a review of the histology of the skin would be, that solely of relieving the pain. That

suggested by a knowledge of general surgical principles would be to treat the wound aseptically at first and later to give drainage by making numerous openings or dissecting away large areas of dead skin altogether, in order to prevent constitutional poisoning and to prevent the destruction, by suppuration, of areas not already destroyed by the burn. The more we consider the histology and the surgical principles involved the more clearly do we see that no treatment can possibly restore life to tissue already dead nor cause new skin to be produced where the old has been destroyed. Any burn that goes deeper than the exfoliating corneus layer of epithelium necessarily results in white fibrous scar tissue.

Perhaps the best immediate treatment for a painful burn will be to brush it over with ninety-five per cent. carbolic acid and remove this in one minute or more with alcohol and follow this with a dressing of carbolized vaseline. If the skin is merely blistered the best plan is to pick the blebs, and leaving the dead skin intact, immerse the part for ten or fifteen minutes in a hot 20% carbolic solution and then dress with carbolized vaseline.

In burns of the third and fourth degree the sloughs should be cut away as soon as it is clear that they are sloughs. Cutting away these sloughs reduces to a minimum the septic absorption and also prevents by giving drainage, destruction of sound areas of skin, by spreading of the infectious material in the subcutaneous tissues. Sometimes there are islands of sound skin left in the burnt area by some accidental circumstance, such as, for instance, one part of the clothing affording more protection than another; these will often be lost if proper attention is not given to drainage!

In wounds where the entire thickness of the skin has been destroyed, the part should be kept clean and allowed to granulate; when it has fairly filled up with the granulations they should be curetted down to sound tissue, as thoroughly disinfected as possible and then covered with Tiersch's grafts. The free flap method such as I have used on the hand in the case reported can be applicable to those cases only where it is desired to replace a contracting, deforming scar, (that has already healed) with normal elastic skin.

ACUTE GASTRIC CATARRH.*

By A. N. Steele, M. D.,

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It has been truly said by some writer or Philosopher that "A man is happy until he learns that he has a stomach." This organ, the location and anatomy of which you are all familiar, is the most overburdened, and hardest worked piece of machinery in the human make-up. It is the receptacle for everything that enters into the composition of the human economy—it is the scape-goat of many ills and pains for which it is not altogether responsible.

I offer you this paper today, the subject of which is so common a lesion and its causes are of such every day occurrence, that it forms one of the most familiar diseases with which we are acquainted. Every acute gastritis is really a toxic gastritis in the sense of a local irritation, such as is produced by toxic substances. In this same way every over-loading of the stomach may be said to act toxically, since every excess is followed by a number of symptoms of irritation which finally cause an acute inflammation.

Naturally, our conception of too much is only relative, and quantities of food which under normal conditions are disposed of without delay, may, under abnormal circumstances have an injurious effect. A convalescent gets an acute gastric catarrh after eating a beefsteak which he could easily digest when he is healthy. A man who has almost starved to death must return to his usual diet very cautiously and gradually. Many persons have a kind of predisposition to gastric catarrh just as others are afflicted with a predisposition toward catarrh of nose and throat; such people are made ill both by the quantity and quality of certain articles of food which have no effect on a healthy stomach. In some this predisposition is undoubtedly hereditary. Hoffman says: Every one has the stomach he deserves; nevertheless great injustice might be done there by to a large number of persons, who, without being dyspeptics, suffer from weak stomachs. Irritation may be caused both by the quality and quantity of food. Spoiled articles of food and drink may even cause inflammation of the mucus membrane of the stomach, probably on account of the inflammatory and firmentative actions of the microbes which have been introduced with them; thus we might speak of a bacillary infection, if by this we understand quite generally that the disturbances are to be referred to the action of the micro-organism, and not, of course, to a direct invasion of them. Ewald states that after examining several pieces of mucus membrane from the human

*Read before Calhoun Medical Society.

stomach while it was yet warm, has never in any case found a trace of bacteria in the tissues, although they were so abundant in the contents of the stomach. Swirnon in examining six cases of diphtheretic membranous gastritis found large numbers of micrococci and bacilla in the membranes lying upon the gastric mucosa, yet he could not detect them in the lumen of the glands or in the tissues. One of the chief functions of the gastric juice is to disinfect the ingesta and thus prevent abnormal fermentation. Where this is done insufficiently or not at all, we get decomposition and the resulting symptoms of irritation. Since we always introduce a certain number of microbes with our food a disproportion must exist between the foreign intruders and the normal production of acid. To this disproportion there must be considered the influence which psychical factors and nervous disturbances exert upon the development of acute gastric catarrh. Under such circumstances weak gastric juice is secreted; the motor and expulsive powers of the stomach are enfeebled; hence any causes of fermentation which may have been introduced are allowwed to grow more rapidly and abundantly. There is at no time a lack of causes of fermentation; we are constantly introducing them in our food and drink.

There are chemical irritants which are toxic in the true sense of this word, that is concentrated and dilute acids or alkalies, metals like copper, antimony, iodine, arsenic, phosphorus, etc. There are also thermal irritants; ingesta which are too cold seem to do more harm than those which are too hot. A draught of ice water or ice beer is often charged with being the cause of gastric catarrh, but we seldom hear of any blame being attached to ice cream, which is just as cold. This may probably be due to the fact that ice cream is eaten slowly, and in small quantities at a time.

The pathology of this disease is a question, from the simple fact that in almost all cases examined death is preceded by some disease which cause changes to take place in the mucus membrane of the stomach other than the changes due to acute gastritis. The most reliable study of the pathology of this disease was made by Beaumont in the case of the Canadian St. Martin. The mucus membrane appears entirely or partially swollen and reddened; its surface is marked with numerous white spots and vesicles like coagulated lymph, between which were very dark red spots.

Symptoms.—Acute gastritis is divided into afebrile and febrile catarrh. The latter is simply an exaggeration of the former, but it may occasionally follow so rapidly that an acute febrile gastritis with high fever may be at once developed. Immediately after a manifest indiscretion of diet nausea appears together with a feeling of fullness,

tension and swelling of the epigastrium, tenderness on pressure over this region, thirst, anorexia, and even disgust for food; accompanying these or at the outset are the general symptoms of giddiness, headache, flashes before the eyes, and prostration. In addition we find the tongue coated at the beginning; especially the organ is often completely covered with a thick tenacious white fur, which may be colored by food or drugs, and which retains the impressions of the teeth; as the disease advances it tends to clear up at the tip and edges. At times herpes labialis develops. There is diffuse pain over the region of the stomach, and painful spasms may also appear. The pulse is small and rapid the secretion of saliva is increased, the oesophagus contracts painfully; spasmodic yawning is sometimes observed. The face becomes pale, the eyes are expressionless, the extremities cold, and a quite specific odor is exhaled from the skin. Now nausea and vomiting set in; the latter, even if it occurs some hours after a meal, consist of the ingesta, only slightly changed, and enclosed in thick masses of mucus; the vomit has a flat or very penetrating odor and an exceedingly bitter taste. This, however, is not due to bile, but to the acrid taste of the peptones together with the fatly acids, such as we find in every artificial digestion. Fresh bile is not bitter, but tasteless. The vomiting tends to be repeated many times, and finally only mucus and bile are raised. At first it occurs easily, but later becomes painful, depending upon whether the spasms involve the fundus or the orifice, thus rendering the act of emesis more difficult, a point to which Skoda has directed attention. Although the bowels are constipated at first, the passage of chyme into the intestines irritate the mucus membrane of the latter causing borborygmi, which may sometimes be heard even at a distance, the expulsion of offensive platus and watery stools, accompanied by some tenesmus. Under proper care the condition disappears in three to five days or it becomes sub acute or chronic.

Febrile catarrh is distinguished from the afebrile form only by the greater intensity of the symptoms and the occurrence of fever from the onset. The latter appears suddenly and may reach 104°F. or more. The skin becomes dry and livid, and the rapidity of the pulse is increased. Formerly these cases were called gastric fever, and were classed with typhoid fever, but we have since learned to sharply differentiate these two conditions, owing to our better knowledge of the nature of the latter.

Ordinarily there should be no difficulty in arriving at a diagnosis, though in some cases we may have to wait a day or two, especially in the febrile form. In the afebrile form we are called upon to differentiate between acute gastritis and duodenal catarrh. In the latter there

may be a damming up of the contents of the stomach causing a reverse action of the stomach; these cases are preceded by some indications of duodenal catarrh, such as intestinal indigestion, constipation, changes in the color of the stools, and as a rule the tongue is clean, also there is usually the absence of dietary indiscretion. There should not be much difficulty to differentiate between the febrile form, and a beginning typhoid fever, the step like temperature curve of which is quite characteristic. But meningitis, peritonitis and hepatitis, may begin in the same way, so that we can only feel sure of our diagnosis after waiting a little while. However, the diagnostic errors in these cases are of little importance as the rapid course of this disease reveals the true conditions.

As this disease is caused by irritation introduced from without, the indications for treatment is obvious. Remove all noxious substances and prevent any disturbances. Empty the stomach by 1-2 to 3-4 quart of warm salt water, tickling the throat with a feather, or finger, a dose of ipecac powder twenty grains, or best of all a hypodermic injection of apomorphia 1-10 to 1-12 of a grain, then keep the organ quiet by withholding food for from 12 to 24 hours. This will give the mucus membrane time to become normal. Should the bowels remain constipated give calomel in doses of 1-4 grain combined with bicarbonate of soda, until you get the desired effect. The antiseptic properties of calomel together with its mild purgative and cholagogue effects makes it the ideal remedy for this disease.

Mrs. C., a stout fleshy widow, sent hurriedly for me one morning, but just before the messenger reached my office I had another hurry call, and sent her messenger for another doctor, telling him I would come as soon as possible, as she was reported to be in a dangerous condition. I reached the house in about five minutes after the other doctor arrived. She complained of difficulty of breathing, or smothering a feeling of impending death if something was not done quickly. her pulse was small and rapid, heart's action quick, but otherwise normal; inability to lie down. The doctor had prepared a hypo. of Nitro glycerine 1-100 grains and was about to administer it when I entered the room. After examining her heart I disagreed with him as to the remedy as I was convinced she was suffering from acute gastritis. In place of Nitro glycerine I gave her 1-10 grains of apomorphia, assuring her that her life was not seriously threatened. In a few minutes vomiting began, and although she had told me that she had eaten nothing since noon of the previous day the first effort brought up a mass of undigested food, some of which she identified as having been eaten two days before. I then gave her a 1-2 quart of tepid water, which was immediately ejected, and after one more violent effort

she brought up the entire leg of a half grown chicken, minus the bones; it had no signs of having been even partially masticated. I then gave her 1-8 grain morphia hypodermatically and left istructions for her to be kept quiet and to have nothing to eat until next day. The next morning I called and found her feeling very much better. I then prescribed calomel 1-4 grains soda bicarb. 2 grains every two hours. Upon my next visit, which was the following day, I found her up attending her usual duties and feeling better than she had for a month.

UTERINE FIBROIDS.*

By J. D. Gibson, M. D.,

BIRMINGHAM, ALA,

Member of Jefferson County Medical Society, Alabama State Medical Association, American Medical Association, American Electro Therapeutic Association and Electro Therapeutic Society of France.

The subject of uterine fibroids has always been one of great interest to the medical profession, and so I hope you will pardon my bringing an old subject before you this evening.

These cases come to us as general practitioners in their early growth and are usually of large size and give much trouble when sent to a specialist.

Usually profuse menstruation with or without pain is the first noted symptom, but as they increase in size the varying degrees of discomfort are reached from moderate pain and menorrhagia to an unbearable degree of both with many nervous reflexes for complications besides disturbance of functions of bladder, rectum, etc.

The question naturally arises, when these cases present themselves, what is best to be done for them? Ergot and tonics—the main stand-by of the general practitioner—while ameliorating the symptoms in many cases, are usually found wanting, and are little more than a makeshift.

The two great factors today in the treatment of uterine fibroids are Electricity and Surgery.

The first is applicable and successful in about 85 or 90 per cent. and surgery will be needed, owing to complications, in the other 10 or 15 per cent.

I don't think it possible to do without either of these two agents, with advantage.

Both have their proper place, and they should go hand in hand, instead of being rivals.

Electricity, probably the greatest boon to mortals given, has its

*Read before the Jefferson County Medical Society.

indications and contra-indications. The incompatibilities of electricity, while not very many, are very important, and require careful observation that they may be avoided.

Dr. A. Laquerriere, in compiling the statistics of Monsier, Dr. Apostoli and others, shows that the immediate and continuous cessation of development takes place in about 70 per cent. of cases, while the larger part of the remainder are finally arrested by patience and perseverance.

Twenty per cent. of all the tumors are both physiologically and clinically cured as far as symptoms and manual explorations can detect. A reduction in size with a relief of all untoward symptoms occurs in 70 per cent. of all cases. These cases are all practically cured except the fibroid, which, while reduced in varying degrees, is not entirely removed; but there is no pain, soreness, nor hemorrhage, and the uterus is as mobile as before the fibroid appeared.

Hemorrhage is arrested in 90 per cent. of all cases, and never fails, you might say, unless a condition is present that contra indicates the use of electricity.

The influence on the leucorrhoea is not easily determined, as a good deal of flow follows the treatment, but after several seances it usually disappears.

There is a marked improvement on the general health of the patient in 80 per cent. of cases.

Causes of failure by electricity: First. Contra indications, viz.: Malignant degeneration, Suppuration of adenexia, Sphacelated pollyp, Torsion of pedicle, Cysts of ovary, Cardiac incompetency. And under this head we might as well class the hysterical intolerance.

Where the current is too timidly and improperly applied, also when is applied too strong, with too long seances peri-utrine irritation and congestions are set up. Also roughness in introducing the intra-uterine electrode produces trauma, and sets up a condition intolerable to electricity.

Again now, abstainance from sexual indulgence, is absolutely imperative on the day of and the day after treatment.

Inability to rest after treatment, Apostoli found in cases most difficult to relieve, even those who lived above the third floor and who had to come and return the same day a great distance on railroad trains, etc. These cases were never able to take the needed rest usual after treatment. The patient should rest on a couch two hours after treatment, and the remainder of the day should be without fatigue.

It is rare when these tumors are relieved by electricity for them to give any more trouble in future, but in young women, when relieved, they have been known to take on new life later, but are usually quickly relieved again.

We have already noted that we would have about 10 or 15 per cent., not amenable to treatment, by electricity, owing to certain pathological complications already mentioned.

When we have an acute imflammatory condition or abscess, we will have all the symptoms exaggerated and probably chills and fever following.

In a complicating cyst we will have an exaggeration of symptoms and the electricity will be badly borne, but not likely to have a febrile reaction.

Hysterical intolerance can, in nearly all cases, be overcome by tact, and judicious management, but in some cases, never.

Malignant degenerations are no longer fibroids and therefore should be treated like other malignant conditions of the uterus, by total extirpation of uterus, and adenexia, that are involved.

Sphacelated Polyp comes under the same heading.

Electricity serves as a diagnostic agent of no mean importance, and should be used as such only in these cases.

Cardiac insufficiency, while it calls for greater care, is not as dangerous as it is in chloroform, or other narcosis.

I believe with Keith, and many other competent observers, that no case, unless the contra-indications are well marked, should be operated upon by ablation of uterus without first giving the patient the benefit of the doubt, and try the effect of electricity. With modern asepsis, and antiseptic surgery and the improved technique operations, on uterus and adenexia, have lost many of their terrors, but best of all is the improved Myomectomy operations. This operation, I think, destined for high rank, in gynecological procedures, and will relieve uterine surgery of much of its opprobrium in the future.

I think it may often be debatable in some cases, which is preferable, Myomectomy or electricity. The Myomectomy has more danger, it is true, but you get a quicker cure with absolute removal of tumors, and the woman is still capacitated for motherhood, and all the duties of the home afterwards.

Myomectomy may frequently be performed through the vagina, and thus lessen the risk.

When you leave out malignant, degeneration, there are very few cases that require a hysterectomy. Ovarian cysts when complicating fibroids, will have to be removed by the knife, and at the same time, while the abdominal cavity is open, a myomectomy may be performed, or removal of uterus, or it may be left, for electricity afterwards, owing to the judgment of the operator at the time.

One great beauty about using electricity in medicine or gynecology,

is its definite and certain action, it is always governed by the same law, and never changes, and is a definite factor in disease.

Electricity, especially the constant current, is never applied in any considerable strength but what your patient is either in a better or worse condition from its application, its effect is usually immediate, and one must ever be on the lookout, and take immediate cognizance of the beacon lights, better or worse, in every case.

One who persistently uses electricity, in uterine fibroids, in spite of its contra indications and without noting the aggravation of symptoms produced, becomes fanatical, does harm to his patients, and brings reproach upon a valued therapeutic agent.. With the Voltaic chemico caustic method, I would advise the occasional combination of the Stattic spark, over abdomen and lumbar region bringing into play its powerful tonic and sedentary effect. Also a combination occasionally with the high tension, high frequency currents, of Darsnvale, applied by means of a black tin electrode to the abdomen, I find of great service.

I find these currents act almost entirely through this power of causing muscular contraction, and also having a very beneficial, soothing and sedative effect. I have seen them expell endometral fibroid or polypi in 2 or 3 treatments, so that the uterus almost reaching the umbilicus in two or three treatments, could scarcely be found under the symphisis pubis without a digital examination at some time. The greatest benefit from these currents usually show themselves in the breaking up of adhesions; the alleviation of the pain and soreness and improving in a great degree the mobility of uterus. I have had patients as an illustration to have to come to my office, for treatment, the first and second time in a carriage, and after that be able to walk, to and from my office afterwards.

Even if a surgical operation is desired, it is certainly a valuable procedure to break up the adhesions, and loosen up the uterus before an effort is made to remove it, but I think few women would submit to an operation after this pain and suffering are relieved.

Mr. President.—In closing this paper I will sum up, in a few words, my conclusions. First. In all fibroids, large or small, unaccompanied by fever or any active inflammation or pus-formation hemorrhage, or no hemorrhage, electricity should be tried. The continuous current should be used and pushed to the tolerance of the patient, and followed by the secondary sinusoidal or Mortous Static wave, until sedation takes place. By this method 20 per cent. will be symptomatuately and physiologically cured while you have 80 per cent. symptomatically relieved ,but the tumor is not removed but greatly reduced in size.

The other 20 per cent. will be very greatly improved, but the majority, owing to complication, cannot be cured by electricity and must be treated by the knife.

TYPHOID FEVER.

Treatment.—The mortality of typhoid fever, when cases are seen from the beginning, in personal opinion should not be over 3 per cent., if the following principles are carried out:

First, absolute rest in bed from the earliest symptom giving rise to suspicion.

Second, the abstinence from the use of medicines, unless these are distinctly called for, for the meeting of some symptom. Mineral acids, fever mixtures, quinine, and the whole mass of drugs, which have been much given in typhoid fever, are either worthless or, perhaps, harmful when administered in the routine manner.

Third, the proper use of remedies boldly and in sufficient dose when they are strongly indicated to meet some symptom which has arisen.

Fourth, the rigid use of baths when the temperature gets to 102½° or above.

Fifth, the administration of turpentine, commencing about the end of the second week, in every case. Both laboratory experience and clinical experience are positive in their concordance in showing that the drug has a specific local action on the typhoid ulcer and the bacillus which it contains.

Sixth, careful feeding: to give enough, but not too much, food, semisolid meat-foods in some cases being preferable to milk.—H. C. Wood, (Inter. Med. Mag., Apr., 1900.)

GONORRHEA.

In the treatment of this affection it is considered essential by many authorities that during the acute stage the medication should be internal, and that injections should not be resorted to until the acute inflammatory symptoms have subsided. The remedy selected for the local treatment of these should be one, which will not injure the delicate and sensitive urethral mucous membrane while sufficiently powerful to destroy the gonococci. It should also assert an astringent effect in order to reduce the congestion and arrest discharge. A remedy which will do all this without giving rise to subsequent cicatricial formation has long been a desideratum. For the purpose, Micajah's Medicated Uterine Wafers have proven of great service. One wafer dissolved in three ounces of water as an injection will give the most satisfactory results. For convenience bougies may be prepared by combining the wafers with cocoa butter and insert into the uretha twice a day, and on retiring.

Selected Articles.

DERANGEMENTS OF THE ORGANS OF VISION, WHICH MAY BE ATTRIBUTED TO AUTO-INFECTION, OR TO AUTO-INTOXICATION.*

By J. H. Woodward, B. S., M. D.,

NEW YORK.

Disturbances of vision and other abnormal conditions of the visual apparatus are often associated with both functional and structural derangements of the organs of digestion and assimilation. Such disturbances in the organs of sight may, in certain cases, be purely functional; while, in other instances, the existence of pathological alterations in those organs may be readily demonstrated. In cases of purely functional disturbances, it may be a question whether the effects are not caused by reflex action from the abdominal viscera, rather than by direct irritation of the visual organs by substances circulating in the blood. When, however, it is a question of actual structural changes in the iris, or in the retina, or in some other anatomical division of the visual apparatus, the idea of a reflex causation should be abandoned; but we may assume, even if we cannot demonstrate the fact, that those changes are due to toxic agents in the blood, or to microorganisms that have become lodged in the affected parts. It is often possible to trace the sources of such poisonous substances to the digestive apparatus. Even though faulty elimination be responsible for the accumulation of them in the blood, it will be found, in a certain number of cases, that the real centre of the mischief is in the ailmentary canal or in the liver.

It is evident that we must examine two sets of cases: (1) those in which the derangement is purely functional; and (2) those in which there is a demonstrable structural lesion.

1. FUNCTIONAL DERANGEMENTS.

a. Neurasthenia.—Of all the common functional derangements of the system, neurasthenia is therapeutically the most perplexing. The victims of it begin with their family doctor; but, sooner or later, they drift about among the specialists in various departments, and they are commonly found haunting the waiting rooms of oculists and neurologists. You are all familiar with their general and their local symptoms. Every one has treated such patients, who complain of pain in the eyeballs, frontal headache, pain in the back of the head, vertigo,

*Read before the Society of the Alumni of the Bellevue Hospital, January 3-1900, as a contribution to a symposium upon Auto-infection and Auto-intox, ication.

inability to read without pain in the eyes or head, blurring of sight, total failure of reading vision after a short trial, lacrymation and photophobia. The dread of natural light may be so marked that dark glasses are worn constantly; while toward artificial light the photophobia may be so extreme that the patient refuses to tolerate it at all. The ocular symptoms vary in number and intensity in the different cases. They may be noted in patients whose general condition is apparently robust. They are sometimes the first indication of the beginning of neurasthenia. I have observed them in youths, in adults, and in old people. I have seen them in people who live in the country, and in those who live in the city, in students, in laborers, in farmers, in merchants, in men quite as often as in women, in people who live indoors, and in those who are generally in the open air. The most common subjective symptoms are pain in the eyes, frontal and occipital headache, inability to use the eyes for reading, vertigo, and insomnia. The objective symptoms are usually a small error of refraction —though it may be a considerable one—and some weakness of the lateral recti muscles, in which loss of power in the interni is most marked; while, occasionally, weakness of a superior or of an inferior rectus is present.

The general symptoms need not be recapitulated. Imperfect stomach and intestinal digestion, constipation and functional disturbances of the liver, are conditions inseparable from, and persistent in, these cases.

Certain patients give a history of some great shock to, or strain of, the nervous system. Very many of those whom I have seen, however, have related no such experience. Without further specification, it may be said, in general, that all were individuals who had not devoted sufficient attention to the sort of food they were eating, or to the manner of eating it.

To my mind it has been a puzzle to understand why a neurasthenic patient should not recover more promptly, if his state was one simply of nervous exhaustion. I cannot comprehend why nerve tissue should require several years of assiduous attention to relieve it of a tired feeling. But if malassimilation and auto-intoxication are constant accompaniments, it is permissible to seek in them an explanation of the phenomena—indeed, under such circumstances, one ought to be surprised should the patients recover more promptly than many of them do. My conviction is that the greatest service rendered to his neurasthenic patients by every physician is that which aims to restore the function of their digestive and assimilative organs.

Undoubtedly, there are cases of neurasthenia in which the derangement is primarily in the nervous system. And there is a limited

number of patients whose ocular and general complaints are due to anomalies in their visual apparatus. An error of refraction, a weakness of the recti muscles, or faulty relationship of the lines of sight to one another, constitute the discoverable defects in the eyes. Proper correction of the error of refraction and restoration of an approximately normal relationship between the visual lines will put these patients on the road to recovery. Yet the goal will not be reached, even in these cases, by local measures alone. Direct ocular treatment seems to be most useful in the early days of the malady. After the condition has persisted a number of years, such treatment will not prove to be of much avail.

Eye strain is not often the cause, I believe, of either the local or the general symptoms of neurasthenia, although it is frequently an associated condition. Exceptionally, however, we do encounter rare cases of nervous exhaustion of a severe type, in which it is the predominating ætiological factor. In recent years especially, so strong has my conviction been that derangements of the processes of digestion and assimilation are the most important conditions in these cases, that I have almost invariably suggested that view of the subject to the attending physician. With my own patients, I have been particular in my attention to the abdominal viscera; and I am convinced that such success as I may have had has been achieved by acting upon the belief that the persistence of the ocular, as well as of the other symptoms, is due to a perennial auto-intoxication.

b. Migraine.—Whenever a case of severe headache, associated with nausea and vomiting, is presented for treatment, perhaps the first impulse of the general practitioner is to look for the cause in some error of diet or digestion; the neurologist is apt to refer the attack to some derangement of the nerve centres; while the ophthalmologist is inclined to assume that the source of all the trouble will be discovered in some anomaly of the visual apparatus. Taking the cases as they run it is obvious that errors in determining their ætiology must arise unless very discriminating attention is paid to the details of each of them. At the first glance, the ophthalmologist may be supposed to have the better of the argument; for disturbances of vision are a very prominent part of the symptomatology. The luminous rings, the rolling clouds, the flimmering, and, finally the hemianopsia, all preceding the pain in the head in the gastric disturbances, naturally suggest that the seat of the malady may be found in the visual apparatus. It is well known that headache is often due to abnormal conditions in the organs of sight. Some such headaches are accompanied by nausea and vomiting. But they are not examples of true migraine. There may be errors of refraction in the eyes of the victims of migraine and there

may be anomalies of the ocular muscles as well. But, beyond relief of the headache and the asthenopia that may persist in the intervals between the attacks of hemicrania, direct treatment of the eyes by glasses or other means will not accomplish anything of a permanent nature.

Migraine presents the characteristics of a true nerve storm. It bursts upon the patient without warning and without apparent reason. The hemianopsia and the occasional tingling and paresis of one half of the body are startling phenomena, but they are transitory. The permanent hemianopsia resulting from cerebral embolism or cerebral hæmorrhage is not, as a rule, preceded by clouds or flimmering, nor is its onset succeeded by severe pains. The question, What is it that originates these nerve storms in which the vasomotor system evidently plays the principal rôle? may be answered conjecturally. I do not think that it is any condition of the eyes, nor can I conceive that it is a state of the brain. The nature of the malady, the recurrence of the attacks after periods of calm, are elucidated by the supposition that the system is being slowly poisoned. Each paroxysm represents a rebellion against such indignity, and an attempt to get rid of the noxious substance.

2. ORGANIC DERANGEMENTS.

a. Rheumatism.—Inflammation of the conjunctiva and inflammation of the sclera are both observed in acute rheumatism. That there is a rheumatic inflammation of the cornea alone is proved by experience; but, as a rule, keratitis is associated with inflammation of the iras as the principal lesion.

Rheumatic iritis occurs as an acute and as a chronic disease. The symptoms of the acute variety are quite intense in the pain, the photophobia, the lacrymation, the pericorneal injection, and in the tendency to plastic exudation between the iris and the anterior capsule of the lens and into the pupil. The chronic variety is less marked in all its symptoms. There is moderate pericorneal injection, moderate photophobia, but marked inability to use the eyes. While the formation of an exudate occurs, as in the acute cases, it is produced more slowly. In both sets of cases, cloudiness of the vitreous in consequence of irritation or inflammation of the choroid is, I believe, the rule. The exudate between the iris and the capsule of the lens forms very tough adhesions, which atropine will usually fail to rupture, even though it is administered early in the case and thoroughly. False membrane in the pupil organizes into a resistant structure that is rebellious to treatment of every sort. In some severe cases, we observe exclusion or occlusion of the pupil, both of which interfere with the forward current of the aqueous humor toward its exit between the iris and the mar-

gin of the cornea. Accumulation of the normal humors within the eyeball will increase the intra-ocular pressure; and a rise in the intra-ocular tension induced by such mechanical obstructions is followed by an attack of secondary glaucoma, but will destroy the sight unless promptly relieved by operation.

In general, rheumatic iritis injures the eye permanently, to a greater or lesser degree. I have said that posterior synechiæ persist, but it should be noted that there are rare exceptions to this rule. Now and then, an eye recovers perfectly from an attack of rheumatic iritis. Relapses are the rule, however, and complete recovery from a relapse should not be looked for. They are not necessarily due to a re-establishment of the auto-intoxication. A sufficient reason for a recurrence of the inflammation may be found in the existence of dense adhesions to the capsule of the lens. The iris is normally extremely active. It responds to light, to convergence, to accommodation, to emotional states, and to a multitude of reflex impulses. Continuous interference with that motility by bands of organized exudate must tend to irritate and inflame an iris that has suffered from an attack of rheumatism. It is not necessary, therefore, to go outside the eye to assign the cause for the relapse. And, in order to dispose permanently of such tendencies, the strain must be relaxed by iridectomy, or by some analogous operation.

Acute rheumatic optic neuritis and acute rheumatic inflammation of Tenon's capsule have been observed. Rheumatic inflammation of the extrinsic muscles of the eyeball is not uncommon. It gives rise to two sets of symptoms: (1) neuralgic pains when the eyeballs are moved; and (2), paralysis of one or more of the recti muscles, usually the external rectus.

Paralysis of an external rectus muscle is frequently observed. There is commonly a history of exposure to a draught of air on the affected side. The affected eye turns toward the nose, and it may not be rotated outward beyond the median verticle lines of its orbit. The patient is confused and incapacitated by the persistent diplopia, which may be suppressed only by excluding the eye from participating in the act of vision. Paralysis of this nature will yield to treatment, and should never become permanent.

b. Bright's Disease.—I do not intend to discuss at length the various phases of albuminuric retinitis, but I wish to report the history of a case of nephritis which seems to me to be pertinent to the subject we are considering:

Miss I. C. M.——, of Dresden Center, N. Y., nineteen years of age, was brought to me by her father, on December 12, 1895. She had been anæmic, but in other respects her health had been good. About eleven

weeks before this visit, while attending a fair, she had become constipated. On September 19, 1895, she had an attack of nausea and vomiting. On September 22d she consulted a physician, who prescribed a cathartic pill, supposed to contain the extract of belladonna. On the 23d, she took another pill; on the 24th, another; and on the 25th, she took two pills; but her bowels did not move until she had taken considerable doses of a saline cathartic. About noon, on September 25th, her sight began to fail, and by night she was blind. She complained of numbness in her hands and feet and dryness in her throat, and during the night she had a slight convulsion. Another physician was called, who noticed the wide dilation of the pupils and other indications of the physiological effects of atropine, from which he conjectured that the patient was suffering from belladonna poisoning. The patient was confined to her bed for five weeks. The numbness in her legs lasted one week, and her hands regained their normal sensation at the end of two weeks. At the outset, her body was covered with a rash, after the subsidence of which her skin peeled. I was unable to obtain any information regarding the temperature range. The father said that she was feverish.

The patient told me that there had been a fog before her eyes from the beginning of her illness, and that, two weeks before I saw her, the blur had increased so that she could perceive light only. Upon examination, I found that her vision was perception of light. Her pupils were widely dilated and did not respond to light. Both optic discs were pale and swollen; the small blood vessels upon them were very tortuous, no hæmorrhages into the vitreous were present. Her urine had a sp, gr. 1010, and contained a quantity of albumin.

February 4, 1896.—She is totally blind. She complains of red and green flashes and wheels before her eyes. There is no reflex contraction of the pupils. Upon tightly blinking her eyelids upon her eyeballs and at the same time making a strong effort to see an object held between her and the light, a perceptible contraction of both pupils took place. The exudation at the optic discs is thinner, and white atrophy of the nerve may be seen through it. Two small patches of chorioiditis are found between the right optic disc and the macula. The retinal arteries and veins are diminished in size. The urine has a sp. gr. 1009, and contains albumin and hyaline casts.

June 10, 1896.—The patient can perceive light, and she can tell when an object passes between her and the window. She has no pain, and maintains that she is perfectly well. Her general appearance is that of a healthy, though somewhat anæmic, young woman. Her right pupil is less widely dilated than the left one; but neither of them responds to light. She can contract her pupils in the manner already

described. The ocular media are clear, and both discs show unmistakable atrophy. A slight exudation is still apparent upon both discs. The urine contains albumin and casts, and has a sp. gr. of 1009.

January 20, 1897.—Her condition is unchanged.

In September, 1899, I was told by a patient from the same town that the young woman was still alive and totally blind. I am informed that the father brought a suit for malpractice against the physician who prescribed the pills, contending that they had blinded his daughter by poisoning her with belladonna.

c. Intra-ocular Hæmorrhage.—Dark objects floating across their fields of vision are seen by a large number of patients. The specks before the eyes so often complained of in functional disorders of the liver are unimportant save in this, that their existence has made it possible to suppose that other and more profound derangements are of the same nature. The muscae volitantes of hepatic disorders are superficial, but they are confounded with floating particles in the vitreous which are due to congestion or inflammation in the retina or chorioid, or to rupture of capillaries in those structures. Such minute extravasations are often a consequence of disturbances in the alimentary canal; and, in order to obviate a repetition of them, which might prove to be a permanent injury, it is essential that this fact in their ætiology should be generally recognized. Hæmorrhages of considerable magnitude into the vitreous, occasioned by straining at stool, have been observed, I suppose, by every physician. Floating particles in the vitreous are encountered, for example, in nephritis, in diabetes, and in simple plethora. In every case it is necessary to direct our chief attack upon improper diet and imperfect digestion and assimilation if we are to succeed in averting that which such ocular manifestations commonly portend; namely, a destruction of function in the affected organs, or the supervention of a cerebral apoplexy.

With this résumé of the more common disturbances of vision that are encountered in cases of auto-intoxication or auto-infection, I shall conclude this paper. Among the topics that have been omitted are diabetes and gout. But, for the reason that the ocular symptoms in those diseases appear to me to be more properly subjects for discussion before a society of ophthalmologists, I shall not bore you with a repetition of them.—New York Medical Journal.

THE TREATMENT OF SPECIFIC AND NON-SPECIFIC VAGINAL CATARRHS.

By Charles W. McIntyre, M. D.,

NEW ALBANY, IND.

I have selected this title because it will enable me to discuss the treatment of vaginal discharges whether they be of a specific nature or not, and because they present many features of sameness.

It is impossible at all times to differentiate the various types of leucorrhea as they are classified in the text books, and indeed a knowledge of such a classification will throw but little light on the treatment of these catarrhs.

In practice I find it only necessary to ascertain whether the vaginal discharge I have under treatment is of a specific nature or not. This information enables me to inform my patient that she may infect any one who approaches her.

The fact that vaginal catarrhs are often found to stubbornly resist treatment is no evidence of the specific nature of the discharges. Many cases of leucorrhea free from any taint are quite stubborn and persist for a long period.

Again vaginal catarrhs are particularly exhausting and there are few diseases which induce the debility and invalidism which accompanies a protracted attack of leucorrhea or gonorrhea. We may now pertinently ask what is the best treatment for these vaginal catarrhs?

There are two demands for treatment, The first being to correct any local or constitutional factor of causation that may be present in the case under consideration. If in other words our patient has anæmia, syphilis, or any other constitutional disease, that must receive appropriate treatment.

Any local condition as laceration of the cervix, must also receive correct treatment.

The second demand for treatment consists in the local applications of remedies directly to the inflamed tissues. There is no doubt that this is by far the most important demand for treatment, because when correct local treatment is employed the discharges cease and the debility of the patient will naturally be lessened and improvement in every way will be a natural outcome.

I have long since ceased to employ copabia and the old specific remedies in the treatment of vaginal catarrhs. These agents are of uncertain value and they often entail severe gastric irritability which makes the patient's debility all the more pronounced.

In the treatment of both the specific and non-specific types of vaginal catarrhs, I have in the last three years employed Tyree's Antiseptic Pow-

der largely, and my results have been all that I could desire. In fact no remedy has ever brought the quick results and satisfactory results which I have at all times obtained from this remedy.

I have one or two teaspoonfuls of Tyree's Antiseptic Powder dissolved in a pint of water and this is injected three or four times daily according to the profuseness of the discharge. The powder is non-irritating, and the odor disappears after its employment is begun.

In gonorrhea or non-specific vaginal catarrh, this powder is alike efficient and brings about a cessation of the discharge more quickly than any agent I have ever employed. I may add that I have never had a failure since I began to employ this agent.

A young married woman came to my office about four months ago asking for treatment of "whites" which had now persisted two months. The discharge was purulent and most profuse. Examination of the discharge under the microscope confirmed my suspicions that she was suffering with gonorrhea. She was put on Tyree's Antiseptic Powder (two teaspoonfuls to a pint of water) three times daily. In a week the discharge was greatly diminished and she used the injections only once or twice daily. At the end of the second week she had scarcely any discharge and only employed the douche every other day.

I lost sight of this patient and did not see her until three weeks ago, when she told me that she had no further discharges and had gotten on well ever since.

I must not forget to add in this connection that this patient took no internal treatment whatever.

A lady applied for treatment of leucorrhea which had persisted for a year. The drain on this patient was very great and she was as a consequence very much debilitated.

I put her on Tyree's Antiseptic Powder as in the above case. This lady was given no internal treatment although she had more or less anæmia. I believed that when the discharge was discontinued the drain on her system would cease and the untoward symptoms would disappear. This proved to be true and my patient made a complete recovery which occupied four weeks. The patient's gain in flesh and her change from a nervous melancholy person to a bright cheerful one was quite remarkable.

A lady forty-two came to the office for a prescription for some remedy to cure an attack of leucorrhea that was most profuse. She was a widow and from all that I could glean from her history I thought the discharge of a specific character though I did not make a microscopic examination. She was put on injections of Tyree's Antiseptic Powder, and this was continued a week. On coming to the office she declared she felt a great deal better and that the discharge was most meagre. After

this she employed the douche only once a day and made a complete recovery, after having employed the treatment in all, three weeks.

A young woman aged sixteen and unmarried had vaginal catarrh which was quite profuse and was also odorous. She had an inflamed tender vagina and was completely debilitated.

She was put on Tyree's Antiseptic Powder, three employments daily. After a week she used it only at night. The end of the third week this lady had no further discharge, was greatly improved in strength, was in fine spirits and now in four months has had no further discharge.

INCOMPATIBILITIES OF HEROIN AND HEROIN HYDROCHLORIDE.

Heroin and heroin hydrochloride form an essential part of so many formulæ for the relief of cough, dyspnea, and pains in the treatment of respiratory affections that it is most important to determine in what combination they will prove most effective, and what are their incompatibilities. Owing to the insolubility of heroin in watery solutions it is necessary to add a few drops of some acid, acetic or hydrochloric, in order to effect its solution. This can be entirely obviated by using hydrochloride, which is freely soluble. The only incompatibilities of heroin and hydrochloride worthy of special mention are the alkalies, such as bicarbonate of sodium and carbonate of ammonium. On the other hand, salts of neutral reaction, such as iodide of potassium or chloride of ammonium may be used in the same mixture, and this also applies to acid salts, such as hypophosphites or acid phosphates. The vegetable expectorants, as ipecac, senega, squill, and sanguinaria, are entirely compatible with heroin and its hydrochloride. Although many physicians employ heroin without admixture very desirable results have been reported from combinations with iodide of potassium, chloride of ammonium, and the vegetable expectorants, according to indications present in particular cases. A word as to the dosage of heroin and heroin hydrochloride may be of interest here. The large doses at first recommended at the time of the introduction of heroin are no longer preferred by the majority of authors, the average dose ranging from 1-24 to 1-12 grain in adults, and 1-120 to 1-60 grain in children. It is advisable not to employ larger doses until smaller ones have been given a trial. Furthermore, many physicians now resort to the hypodermatic use of heroin hydrochloride in cases in which it is desirable to obtain an immediate effect, and especially in the treatment of spasmodic conditions, such as asthma, care being taken in the preparation of solutions not to add the drug until the water has partially cooled.

Editorial.

JNO. C. LeGRAND, M. D.,.....Editor and Prop.

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Excision of the External Carotid Artery.

Dr. William Perrin Nicholson of Atlanta, Ga., read a paper upon the subject of "Excision of the External Carotid Artery in cases of inoperable malignant diseases of the Face" and reported two cases upon which operation had been recently done.

The first case was a sarcoma of the nose which began apparently as a polypus about eight months before. This was removed several times but reoccupied promptly after each removal. When seen a few weeks before the operation this had extended sufficiently to completely obstruct the nose and cause great pain by constant pressure. At the time of operation this had progressed in a few weeks only so that the growth pressing under the orbit had forced the right eye out of position and there had been also an extension upon the forehead upon the left side. The patient suffered intense pain which required constant use of morphine for its relief. The right common carotid was excised on October 3 and the

wound healed promptly. The enlargemetn upon the left side of the forehead broke down and the large abscess was opened a few days after the operation. The pus from this, or the discharge from the nose, set up a violent ophthalmia from which the patient suffered for a week or ten days. Two weeks from the day of the first operation the carotid upon the left side was removed and very soon the symptoms improved in every respect, the patient was relieved of suffering, and the growth not only checked but it apparently began to recede with the prospects of a material improvement in his condition. The second case was one of inoperable sarcoma of the upper jaw of three month's duration and of very rapid growth. In this case the interval between the operation was longer than in the first, on account of the occurrence of a severe secondary hemorrhage on the seventh day, which was due to tying the vessel too close to the bifurcation. The first operation in this case relieved the patient of all symptoms caused by the rapidly increasing pressure, and the growth apparently subsided materially. The second oepration had not been performed long enough to give much idea as to how much permanent decrease there would be in the tumor.

In commenting on the operation, it was claimed that in these cases the patient was simply doomed if nothing could be done, and this appeared to be the only recourse that offered any hope of benefit. He had performed various operations upon the external carotid artery in the case of malignant diseases, having tied the vessel twenty-six times, four of these being cases of double ligation. The operation had not been accompanied by any mortality. Little could be accomplished by simply ligation of even both carotids because the circulation was re-established so rapidly that the nutrition could not be cut off with any degree of permanence. The operation of excision as recommended by Dawbarn seemed to be the only proceedure that offered any hope and while this would not perhaps produce much permanent effect, yet it seemed undoubtedly true that the lives of patients could be much prolonged and their sufferings greatly lessened. The operation was one of considerable magnitude and dealt with structures of great importance anatomically, yet the result demonstrated that there was comparatively little danger in the performance of it.

Dr. Davis' Resignation of the Secretaryship of the Southern Surgical and Gynecological Association.

The New York Medical Record in its report of the proceedings of the Atlanta meeting says:

"Much to the regret of the members, Dr. W. E. B. Davis resigned the secretaryship, owing to the pressure of other duties, after having served the association ably and efficiently from its organization to the

present time. A resolution was offered and unanimously adopted thanking Dr. Davis for his efficient services, tireless efforts, and faithful devotion to the interests of the association during a period of thirteen consecutive years."

The Buffalo (N. Y.) Medical Journal stated editorialy that:

"Dr. W. E. B. Davis, of Birmingham, Ala., who has been secretary of the association from its foundation, voluntarily retired from the position and his mantle falls upon Dr. W. D. Haggard, Jr., of Nashville, one of the active younger members of the association. In surrendering his office Dr. Davis leaves in the hands of his successor a splendidly organised body of professional workers, that owes much to his faithfulness and great executive capability. The medical profession of the South owes more to Dr. Davis than it can repay in many a year, no matter how highly it may choose to honor him."

What Shall be the Future Attitude of the Competent Medical Man Toward the Life Insurance Companies?

"The Medical World" says: We do not remember having seen this question discust along the lines we now follow, yet it is of considerable interest to the practictioner and of momentous import to the companies. There are approximately thirty "old line" life insurance companies doing business in the United States today. The various national and local fraternal organizations can hardly be counted. Nearly all the great "secret societies" have insurance features which are pretty generally taken advantage of by their members. Every one of such organizations place their first dependence upon the judgment of their examining physicians when they decide upon the acceptance or rejection of proposed risk.

It is mainly the good judgment and skill in examination shown by the physician to which all these companies must look for their protection from undue loss by deaths. One not initiated would think that they would not only be extremely cautious in the selection of examiners, but would also pay such men in proportion to the responsibility involved. We all know that this is not the case. The highest fee paid by any of the companies for examination involving the safety of $1,000 is $5.00. No capable attorney would give a written opinion on a matter involving a like amount for less than five times the fee. Even tho the fee was ridiculously low, it has been still further reduced by some of the companies to $3.00. The fraternal organizations have many "examinations" made for $1.00. One of the "ten cent" companies even has the assurance to approach capable practitioners with the proposition to pay twenty-five cents each for life insurance examination made.

The companies do not admit that a problem exists in this matter any further than the question of just how low they can squeeze the fees. We believe that a life insurance company, like any other corporation or individual, will generally get just about what it pays for. Two elements: professional skill and judicial opinion upon a business matter involving one or more thousand dollars are involved. Such fees are refused by many capable men, who refuse to lower their professional dignity by doing such work and shouldering such responsibility for such a fee. Many practitioners will not make a life insurance examination for less than $5.00. In either event, the company who pays the $3.00 fee is the loser. In the first case they are losing men of highest skill and best judgment, and are taking up a lower class of practitioners who are glad to do work at almost any price. In the second case they are getting just what they pay for; which is superficial examination, and lack of concern upon the practitioner's part as to whether the risk is a thoroly first class one or not. It is only a question of time until the man who makes life insurance examinations for $3.00 will be found to be the same man who buys no modern books; who does not belong to a medical society; and who reads no medical journals.

Any one acquainted with the facts as they exist today knows that as a rule those companies paying a $5.00 fee have a better class of examiners than those paying the lower prices. Such facts must militate against the ultimate safety of the funds of the lower class companies. If any factor is of prime importance, it is a thoro examination by a capable man, in order that the medical director may estimate the desirability of the acceptance of the risk. A lower class of examiners, and loss of interest in the outcome of the matter, must in the end secure for the company a lower grade of risks. Lower grade of risks will assuredly increase the death rate of such company. Increast death rates mean less profits to the holders of a policy in such companies.

The personal influence of the doctor for and against life insurance companies does not seem to have been estimated as of value. We know many practitioners who examine for both the $5.00 and the $3.00 fees; and they are often consulted by their patients as to the desirability of selecting a certain policy after they have been solicited by agents of both companies. The well informed doctor knows that all the old line life companies are so far sound; he knows that the $5.00 fee company is securing a better class of risks than the $3.00 company; he knows that his interest is warmer toward the company paying him the better fee; he is certain that a few years will tell in the increast death rate of the lower feeing company; and what wonder that a word from him sends the business to the higher grade company. We know of one instance where such advice has sent many thousands of dollars to a company which treats its examiner fairly, where, had all things been equal, the doctor could have had no preference.

Doctors carry considerable life insurance on their own lives, and in selecting a company are pretty apt to think of these things. When they place their insurance with the $5.00 company, their interest in that company is then yet further augmented.

The matter is of importance to policy holders in that the lower fees encourages the acceptance of lower class risks, and this must in time react against the company, with the result of lowered profits and less reliable insurance. It is important to the physician, because if we are so easily induced to render our services so much below their true value it will be a short time only till attempts at further reduction are made.

In some sections of the country the medical societies have taken the matter up and refused to examine for less than the ordinary $5.00 fee. This is the only way to reach companies of such tendencies. If the profession were organized more thoroly, united action would restore the old $5.00 fee by every company. Much can be done by local united effort, even as the case stands.

There is no ground for the claim that the company cannot afford to pay the $5.00 fee. It is pretty generally known that the actual cost of insuring a life at the age of thirty is less than $12.00. The average premium paid at that age is about $32.00. Of this amount the doctor gets $3.00; the solicitor 60 per cent. of the whole, or $19.20. This leaves $22.20 paid out of $32.00 for the first year. Succeeding years give the company an excess of $20.00, since neither the doctor nor solicitor are to pay. There can be no claim for poverty. It is the conscientious doctors who have made the life insurance companies stand on their secure pedestals to-day. They have their carefully computed tables of "expectation of life," and past experience has shown them correct when large numbers of lives are considered. Continued exercise of the policy of lowering the thoroness of their medical examinations by accepting a lower class of examiners, or by placing a premium on carelessness in examination or lack of interest in the results, will cause these tables to be revised within a few years.

All the cities are now loaded with life insurance, and most of the great companies are making strenuous efforts to secure business in prosperous country districts. We know that they find in such regions examiners entirely the equal of their city examiners; yet in more than one instance it is known that the country practitioner is tendered the $3.00 fee by the same company which pays its city examiner $5.00 for the same work.

Slight acquaintance with the facts in the case must convince any one that the profession has not been treated fairly by the life insurance companies. They count on our lack of organization and on our petty jealousies to further their aims. Too often we would spurn to make the

painstaking examination and prognosis; execute the papers; stake our reputation upon the exactness of our labors; and give judicial opinion upon the risk, for the munificient retainer of $3.00, did we not know that our neighbor across the way would get the fee if we refused it. Thus our thraldom grows. A long time ago physicians were educated slaves trained by their masters. The physician of to-day has yet remained free. He trains himself, thus far he supports himself, and is buried by his friends; but unless he wakes up quickly he will be throttled back into slavery.

Every life insurance company keeps tab on every physician. They can tell at a glance where he graduated; how long he has been practising; whether he has a membership in medical societies; together with other items of interest concerning him. Yet they do not take the initiative to secure the best man as their examiners.

Every medical director of every life insurance company knows that he can ascertain the professional and moral reputation of any physician; he knows, also, that the better class of practitioners are found holding membership in some medical society. Such information might serve as a warning to him, but hitherto it has not.

It would be an easy matter to secure the signatures of every physician in your county to an agreement (with penalties attacht for violation) to refuse to make an examination for life insurance for less than $5.00. This is all that is necessary. They will meet you with assertion that they will secure an examiner who will come from a distant point to make required examinations. When they try it, you can exhibit to them the policy of the applicant in question placed in some less penurious company.

Action in self defence has been delayed too long. If you will secure such a paper drawn up in such a way that every signer will understand that he and all other signers are firmly bound, a special decree from the life insurance companies will be quickly forthcoming which will guarantee to you the safety of your former beggarly $5.00 fee.

Doctors take too little interest in anything outside clinical work; even their families seem to be neglected. A little organization; a modicum of business sense; a grain of activity, will coax rapid improvement in the finances of our body medical. Act!

ACUTE NEURASTHENIA.

It may be novel to see the word "acute" placed before the word "neurasthenia," but a correct interpretation of disease phenomena will make clear, I think, that these terms are employed correctly. In neurasthenia we have a loss of tone of the entire nervous system, together with neuralgic pains in various parts of the body. If we will study the

nature of nervous prostration we will find that the term acute neurasthenia is no incorrect employment of terms.

Nervous prostration may develop as a result of continued mental strain, or it may be the result of neuralgia or any disease which taxes the energy of the nervous system. It often occurs in the course of pleurisy or pneumonia as a result of pain and fever and other debilitating elements of the disease. The supervention of acute neurasthenia in the course of acute or chronic diseases is dreaded by all practitioners because heart failure or a decided degree of asthnia may be present, and from either of these influences the physician has much to dread.

Now the treatment of acute neurasthenia, whether it appears as a result of nerve strain, worry, or mental or physical cause is about the same. We are under the necessity of giving these patients a nerve sedative, that the high tension may cease to be a factor, and that natural sleep may be secured to the patients and in that the brain and nerve centres can secure rest and consequent recuperation. But when we are deciding upon a remedy we must be sure not to give the patient a drug which will depress the heart, or one which is followed by secondary effects which will work injury to our patient.

In managing these cases no remedy has answered the demand so well as Daniel's Conct. Tinct. Passiflora Incarnata. I employ this remedy in doses of one to two teaspoonfuls every two to four hours, according to the severity of the symptoms in the case in hand. This remedy is an efficient anodyne, soporific, sedative and nerve stimulant, and it has never disappointed us in these cases. The remedy, much to its value, is slightly laxative and the constipation which often makes all the elements of a case worse, soon disappears when this agent is given with regularity.

We may assume with correctness, and this assumption is borne out by the experience of all observers, that the patients must be brought to suffer no pain, and to sleep adequately—if we fail to secure these results we shall see our patient getting worse. Daniel's Conct. Tinct. Passiflora Incarnata acts promptly as an anodyne and sleep producer and our patients make substantial gain from the time the treatment is fairly started.

Very often when we fail to treat these cases of nervous prostration we shall find that they become melancholy—and often what is indeed a most tractable case will deepen into a nervous affection which may render our patient an invalid.

The truth is these patients from the abundance of melancholy and pain often commit suicide.

In this connection, too, I may pertinently add, that even mild types of nervous prostration should be treated early and in a correct manner—and in this way we will avoid the supervention of some of the most dreaded manifestations of nervous disease.

REFLECTS CREDIT

By being prescribed by the leading physicians of all schools for the leading women of all classes. Where immediate and harmless effects are desired, in either primary or chronic discharges from the vagina. In promptness and harmlessness nothing equals

TYREE'S POWDER.

Its effects are the same when engaged in social festivities as when reclining in bed, because it is quick to act, slow to harm and simple to use. No corrosion, smarting or puffiness of parts, nothing to grease, stain or smell. Simply a pleasant soluble powder, which when added to water and used as a douche or in the bath, checks odors and discharges of all kinds and produces a feeling of absolute cleanliness and refreshness at an expense of about 2c. Enough to substantiate these claims will be sent *once only* for 10c.

WAR DEPARTMENT.
SURGEON-GENERAL'S OFFICE, WASHINGTON, D. C.

"The exact antiseptic strength of Tyree's Pulv. Antiseptic Comp. is one part of the powder to fifty of water (1-50)." W. M. GRAY, M. D.,
Microscopist to the Army Medical Museum.

"An excellent preparation and purely antiseptic."—DR. S. HEMMINGWAY, Blackwell's Island Hospital, N. Y.

"A preparation of unquestionable merit."—*Maryland Medical Journal.*

"I find it of very great value."—DR. G. F. HULBERT, Woman's Hospital, St. Louis, Mo.

"I employ a solution of Tyree's Antiseptic Powder, which consists of, parts, Sod. Bor. 50, Alumen 50, Ac. Carbol. 5, Glycerin 5, the cryst principles of Thyme 5, Eucalyptus 5, Gaultheria 5, and Mentha 5."—DR. LLEWELLYN, Surgeon to Providence Hospital, Eastern Dispensary, and Pres. Med. Assn. of the District of Columbia.

COLUMBIA MATERNITY HOSPITAL,
WASHINGTON, D. C.

J. Wesley Bovee, M. D., Gynecologist to Columbia and Providence Hospitals, and Clinical Professor of Gynecology in Columbian University, Washington, D. C., says: "The sample of Tyree's Antiseptic Powder sent to Columbia Hospital for Women for my use has given most excellent satisfaction. In Vaginitis and relaxed vaginal walls as well as some forms of Inflammation of the Neck of the Uterus, I have found it unusually beneficial."

OLD MARION STREET MATERNITY HOSPITAL.
W. BALDWIN WAYT, M. D., MED. SUPT.

The results obtained from your "Antiseptic Powder" were most satisfactory, being used in cases of Gonorrhea and Leucorrhea, and results obtained were most pleasing, relieving the symptoms in both cases. With best wishes,
Very truly,
W. BALDWIN WAYT.

J. S. Tyree, Chemist. Washington, D. C.

Miscellaneous Notes.

J. S. Tyree, Manufacturing Chemist, has enlarged his advertisement in this Journal from a half to a full page.

The Pan-American Medical Congress, which was to have been held at Havana, Cuba, Dec. 26-28, has been postponed to Feb. 5, 1901.

The annual banquet of the Jefferson County Medical Society will be given at the Arlington Hotel, in this city, on the evening of Dec. 28.

St. Vincent's Hospital, Birmingham, which has just been completed at a cost of $200,000, opened for the reception of patients on Thanksgiving Day. The hospital has a capacity of 200.

A bill forbiding the reckless and indiscrimate sale of deadly drugs, and especially directed against cocain, will be introduced in the legislature at the instance of the physicians of Birmingham.

Bills have been introduced into the State Senate and House of Representatives asking an appropriation of $25,000 to relieve the insane hospital at Tuscaloosa from its present overcrowded condition. At prsent 1,500 patients are crowded into space intended for 1,000, and halls and reception rooms have to be used for patients.

The following physicians have recently located in Birmingham: Dr. Gaston Torrance, Dr. John G. Pittman, Dr. Geo. P. Heard and Dr. Carlyle Yates. Dr. N. F. Hix has located at Gate City, a suburb of Birmingham

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The Journal of the American Medical Association says:

Dr. Thomas W. Ayers, Anniston, has accepted a hospital appointment from the foreign mission board of the Southern Baptist Convention, and has been assigned to Hwang Hien, North China.

At a recent meeeting of the Jefferson County Medical Socieay the following gentlemen were elected officers for the ensuing year: President, Dr. W. E. B. Davis; Vice President, Dr. H. L. Martin; Censor for five years, Dr. E. P. Riggs; Health Officer, Dr. J. M. Mason.

The following class officers for the Medical College of Alabama for 1901, 1902 and 1903 have been announced: Class of 1901—President, J. L. Bryan, Brundidge, Ala.; Vice President, H. De Lameter, Utica, N. Y.; Secretary and Treasurer, L. W. Roe, Mobile; Historian, J. O. Enor, La Pine, Ala.; Prophet, V. W. Newburne, Whistler; Correspond-

ing Secretary, E. G. Bingham, Birmingham, Ala. Class of 1902—President, S. G. Hamilton, Newman, Ala.; Vice President, J. F. Williams, Mauville, Ala.;Secretary and Treasurer, S. C. Meigs, Centerville, Ala.; Historian, J. S. Turner, Wainwright, Ala.; Poet, W. A. Trueblood, Mobile; Corresponding Secretary, H. C. Crelley, Auburn, Ala. Class of 1903—President, H. S. Stallings, Henderson, Ala.; Vice President, I. F. Hutton, Abbeville, Ala.; Secretary and Treasurer, H. S. Wilson, Longview, Ala.; Poet, W. W. Stevenson, Tallapoosa, Ala.; Critic, H. O. Sparks, Spring Garden, Ala.; Historian, T. D. Larkin, Demopolis, Ala.; W. A. Cheek, Millville, Miss.; J. D. Smith, Oneonta, Ala. The commencement speakers are: Salutatorian, Tom G. Burke, Meridianville, Ala.; Valedictorian, W. D. Partlow, Ashville, Ala.

W. C. Frederick, M. D., Lono, Ark., says: I have used S. H. Kennedy's Extract of Pinus Canadensis (Dark), one to three of water, in sore throat from cold, with splendid results, and have now under treatment a little boy, three years old, suffering from strumous diathesis, who has been afflicted over a year with otorrhea. Have been using as an injection two drachms of S. H. Kennedy's Extract of Pinus Canadensis to four drachms of water, three to five drops, two or three times a day, the ear previously cleansed with castile soap. The little fellow commenced to improve from the very first start, and is rapidly improving daily; the discharge has almost ceased. He has been on this treatment for about two weeks.

What right has any firm, whose business is to furnish the physician with his principal weapons, to place upon the market pharmaceutical preparations of unknown medical value? Should we not expect, yes even demand, that the producer of fluid extracts make his products conform to some standard of excellence—that he shall indicate what effects his fluid extracts may be expected to have ere he sends them forth from his laboratory?

It has been shown that even drugs selected with care vary most extraordinarily in their percentage of active principles. Witness, for example, this statement by the editor of a leading pharmaceutical journal who knows whereof he speaks:

Bulletin of Pharmacy, January, 1899.

"Professor Puckner assayed nineteen samples of belladonna leaves procured, mind you, from dealers who were told that only the best was wanted, and that purchase would depend upon the results of assay. He found these nineteen samples to range in alkaloidal content from

.01 to .51 per cent! The strongest sample fifty-one times as strong as the weakest."

The most careful treatment of such drugs, with the choicest menstrua, and by the most approved processes, will yield preparations that may be fair to look upon, but in medicinal value they will vary just as much as the crude drugs from which they are made. The compensatory remedy for this unfortunate condition is standardization—chemical standardization when practicable, and when that method is inadmissable, as it often is, physiological standardization. It has been found that certain important drugs cannot be assayed chemically, as their medicinal virtues reside in unstable bodies and these are readily decomposed in the analytical processes. For this reason the strength of such powerful and useful drugs as digitalis, aconite, convallaria, strophanthus, ergot, cannabis Indica and many others cannot be determined satisfactorily by the analytical chemist. However the problem which proved to be an insurmountable difficulty to the chemist, was solved by the pharmacologist with ease. He tests upon living animals all drugs that cannot be assayed chemically. Dogs, rabbits, fowls and guinea-pigs receive doses of the preparations under examination. Acute observations of their physiological effects are made, variations are noted and corrected, until the preparations correspond in medicinal strength with the adopted standard extracts.

Formerly the physician was obliged to make his own physiologic tests of ergot, digitalis, and so no; not upon dogs and guinea-pigs, however, but upon his patients. The old way was to begin with small doses of powerful drugs and then push them until the desired effect was produced. The new way is a much better one; it is safer for the patient, more satisfactory to the physician, and it is more scientific. Prompt results are assured, for the physician knows just how much fluid extract of ergot, aconite or cannabic Indica he need include in his initial dose to secure a definite result.

The name of the greatest pharmaceutical manufacturing house in this country is so closely linked with the phrase, "drug standardization", that the mere mention of one suggests the other. Parke, Davis & Co., began years ago to manufacture a full line of standardized fluid extracts that are guaranteed to be of definite and uniform strength. More recently they advised and perfected methods for standardizing physiologically those important drugs that are incapable of analysis by chemical processes. Parke, Davis & Co., have done a great deal for the medical profession and for humanity, and standardization, more especially physiological standardization, is one of their greatest achievements.

THE PROPER DOSAGE OF REMEDIES.

How often does it occur that a patient will not improve, but remains in statu quo, under the medication of a competent man who is perhaps a little too careful. But when at the advice of a colleague larger doses are given, it is not unusual for the patient to make a rapid recovery and to see the same treatment, suggested more by experience than by text books, crowned with success.

And this is the condition of affairs not only with Galenical preparations, but with reference to proprietary remedies which have come to stay. It will be found by all who will investigate them that they are generally safe, but that the doses are as a rule somewhat too small. The manufacturers are naturally guided in their dosage by the standard works on materia medica and will not transgress the limits there set down. This is certainly a wise procedure on their part and yet a certain latitude may be taken with the directions concerning dosage. Thus in the treatment of rheumatism, tongaline may be given in doses of three teaspoonsfuls

Five Kingsbury Pianos

Go to the A. C. F. College,

Tuskegee, Alabama.

Another Victory for America's Famous Piano!

After investigating various other makes of pianos, Dr. John Massey has given his order for five handsome Kingsbury Pianos, to be used in the A. C. F. College, which is one of the leading industrial institutions in the South.

IT WAS NO LEAP IN THE DARK, for the Kingsbury has been used in a number of Colleges near home for several years, and Dr. Massey knew its reputation. Among these are "The Cox Female College," College Park, Ga ; "Southern Female College," LaGrange, Ga.; "Tuscaloosa Female College," Tuscaloosa, Ala.; "Anniston Female College," Anniston, Ala.; "Southeastern Agricultural College," Abbeville, Ala.; "Agricultural College," Wetumpka, Ala.; "Gordon Institute," Barnesville, Ga.

I give them all as references as to the high quality of the world renowned Kingsbury. Write for prices.

E. E. FORBES, Sole Agent,

26 Dexter Avenue, MONTGOMERY, ALA.

Branch Houses at Birmingham, Anniston, Ala., and Rome, Ga.

and even of four if the exigencies of the case demand it, despite the fact that the manufacturers advise but one to two.

Far be it from us to desire to become the advocates of heroic medication. If such is really necessary, counsel should be first sought in order to avoid all possible danger. On the other hand, too much timidity is reprehensible and familiarity with drugs, their doses and action will soon put the physician in the position of being able to use them to greater advantage to himself and to his patients."—Ohmann-Dumesnill, M. D., in the November issue of the St. Louis Medical & Surgical Journal.

THE CULTURE OF AMERICAN GINSENG.

Some Accurate Information Regarding This Valuable Plant.

The subject of growing Ginseng has recently received so much attention from the agricultural press of the country and from circulars and pamphlets sent broadcast throughout the country by dealers, that hundreds of people are being induced to try its culture.

Many of the articles are written by people who have no personal

EVERY PHYSICIAN Has a certain class of patients who worry him a good deal, for while not being exactly ill or confined to their beds, they are always complaining of a feeling of depression, loss of energy, restlessness, insomnia, and a general feeling of "je ne sais quoi;" and while these symptoms may indicate a certain form of neurosis or nervous debility, he is at a loss as to what to prescribe, for while there are numerous remedies for nervous diseases he is often puzzled as to which to use. It is in this class of cases that CELERINA, a combination of Celery, Coca, Kola and Viburnum, is indicated, for while not acting as an unnatural stimulus, it soon restores the tired and jaded nervous system to its normal condition, and brings about a feeling of buoyancy and energy that will be pleasing and surprising to both physician and patient, and will induce him to confirm the verdict of his brethren all over the world as to the virtues of this preparation. It is put up in elegant and palatable form, and being made of the best material in large quantities, it is always uniform and certain in its results.

RIO CHEMICAL CO., St. Louis, Mo., U. S. A.

knowledge of the best way to grow it or of the profits to be derived thereby. Others are written by dealers who have seeds and plants to sell, and in both instances as a rule the information is second hand and unreliable. The most extravagant figures are given showing enormous yields produced on a given acreage and Monte Cristo fortunes to be made out of a paltry investment while one loafs in the back yard watching the gold dollars sprouting.

Certain dealers have sent out figures informing the public that $5 invested in their seeds and plants will show a value of $44,340.00 the fifteenth year.

A million dollar bed in twelve years from a $1,000 investment is advertised on another page. A value which cannot be obtained except perhaps in small quantities is placed on the seeds and young plants and the ratio of increase and loss is given very accurately and more extravagantly on paper. Can any of these versatile writers please inform us how many turnips can be grown on a $5 investment in twelve years, the price the roots and seeds will bring each year and how rich a man will be at the end of that period? Certainly not and information pretending to figure it out would be absolute nonsense.

An article on Ginseng entitled "Valuable Farm Land" appeared in the St. Louis Republic a short time ago and was extensively copied by other papers in the south and Southwest. Among other wild statements the writer said that seeds bring five cents each (another writer says there is unlimited demand at twenty-five cents each) and yearling roots 20 cents each; that the eighth year an acre should produce 3,120,000 seeds which sell at five cents each, giving an annual income to the fortunate grower of $100,000.00 from the seeds alone. He further states: "Say that a full crop of seed from one acre is available for planting. That will be 3,120,000 seeds. Allow for the loss and failure to generate of 1,120,000 seeds. This will leave 2,000,000 seed that are practically sure to generate and create 2,000,000 roots. In eighteen months these roots will be ready for market, and can be sold direct to consumers, the present price being 20 cents each or a total of $400,000 from the Ginseng crop in eighteen months. This crop of 2,000,000 roots would require a space of approximately forty acres. One acre should produce 52,000 roots, which at the market price of 20 cents each, should, after eighteen months, bring a return of $10,400."

Could anything be more baldly ridiculous. Let us suppose that only 1,000 gardeners had the above success as to yield. This would mean over three billion seeds put on the market each year, which at five cents each would require $150,000,000 annually to pay for them, not to mention the value of the roots.

Suppose further that the ratio of increase both in yield of crops and

number of growers continued the same for twenty-five years there would not be money enough in the world to buy a single year's crop. China, the source of demand for Ginseng, would have used all their wealth in its purchase long before the period of twenty-five years had elapsed; notwithstanding these air castles there is enormous profit in growing the plant, but it depends on the individual grower as in any other crop. The right conditions for its culture must be supplied, either naturally or artificially and intelligent cultivation given. There will probably always be a good demand for the roots at high prices, and it is an article commanding cash at all times.

These conditions for growing are readily found in nearly all the States of the Union or can be produced at reasonable cost of labor and material. They may be stated in a few words: A rich, deep, well-drained, and moist soil, containing abundant decayed vegetable matter and not too heavy or clayey. Humus or vegetable mold, obtained by using decayed forest leaves is extremely beneficial, as is also thoroughly rotted compost. Shade sufficient to keep off the direct rays of the sun is almost necessary, particularly in sections where the heat is excessive. Add to this careful cultivation and you have the secret, if there really be any, of growing Ginseng successfully. Lath covers are perhaps the best artificial shade and apple trees have been found good to keep the ground protected from the sun. At maturity the roots must be carefully and properly prepared for market, and the extra care taken to produce a fine article, clean, well graded and perfectly dry is more than repaid by the much higher price such roots will bring.

The writer who has had many years of experience growing this root will be glad to give fuller information as to the best modes to be used in its cultivation, but would warn the reader against the wildly extravagant articles that appear from time to time and which will damage rather than help anindustry that really does promise unusual returns for the labor and expense necessary to cultivate it successfully.

Harlan P. Kelsey,
Tremont Building, Boston.

NEW YORK ACADEMY OF MEDICINE.

Section of Orthopaedic Surgery.

Meeting of Nov. 16, 1900.

Fracture After Femur at Birth.

Dr. T. H. Myers presented a baby one month old under treatment for fracture of the femur just below the trochanter minor. The child was the second of twins and presented by the breech. The forceps failing, a hook had been used and caused the fracture with the very unusual displacement of the lower end of the upper fragment backwards in spite

of the tendency of the psoas and iliacus to pull it forward. The next day the child was in great distress. There was extensive ecchymosis at the seat of the fracture, ⅜ in. shortening, oedema of the limb and eversion of the foot and, on any slight motion, the muscles attached to the anterior superior spine were thrown into a marked spasm which drew the lower fragment forward. A plaster of Paris jacket was applied in which was incorporated a steel bar, ¾x⅛ in., extending from the angle of the scapula to the toes, and bent at right angle at the buttocks and the heel. Traction was made and eversion overcome by adhesive plaster applied to the limb and fastened to the steel foot-piece. The plaster of Paris enclosing the pelvis provided secure counter-traction. A light plaster of Paris bandage secured the limb to the splint and held back the upper end of the lower fragment. A fenestrum permitted the dressing of the cord. The child fell asleep at once on this application which made after attendance easy and promoted the comfort and general health of the patient. No displacement. Shortening ⅛ inch.

Dr. V. P. Gibney said that fixation had been secured in an admirable manner. He asked why the limb had been flexed.

Dr. Myers said that he had in that way sought to relax the psoas and iliacus muscles in order to reduce the unusual displacement. He had also seen a directly lateral displacement in a case of fracture of the neck of the femur probably caused by traction with the hook.

Dr. S. A. Twinch related the case of a child whose right femur had been broken at the junction of the middle and upper thirds in a difficult labor. The next day the limb was oedematous and almost black. He had put the limb in a plaster of Paris spica with the thigh flexed nearly at a right angle and the leg flexed. Eighteen days later the dressing was removed and the bone was found united in good position but with considerable callus. He recalled a recently reported case of the same kind in which a good result followed retention in place for three weeks of a starch spica bandage. The patient had been examined when 20 years old, and it had been impossible to tell which leg had been broken.

Dr. G. R. Elliott said that the mechanical problem was how to secure apposition and fixation, a problem well solved by the use of a steel band and plaster of Paris but capable of solution by easier methods as by the use of adhesive plaster.

Dr. A. B. Judson said that the fractures in infancy usually united with great readiness and but little ultimate deformity.

Dr. H. L. Taylor said that when the femur was broken in so young a child deformity was not an uncommon result which he thought could not follow the method exhibited.

Dr. M. G. Campbell, of Atlanta, Ga., commended the skill and carefulness with which the baby had been treated which were in marked con-

trast with the too prevalent idea that nothing of importance could be done for one so young. Before pain had been relieved and muscular spasm overcome rest had been impossible and feeding difficult, two things on which the welfare of the baby absolutely depended.

Dr. Myers said that the common method of placing the child in bed on its back and suspending the legs vertically made nursing difficult and did not control the position and secure immobilization so well as had been done in his patient, who lived at home and was conveniently carried to the hospital for attendance.

INCIPIENT HIP DISEASE.

Dr. Judson presented a girl 7 years of age with symptoms of disease of the left hip of twelve weeks' duration. There had been lameness and pain in the knee, the latter so severe that the child had to be lifted very carefully. Rheumatism was excluded. Nighteries had followed unusual exercise in the day time. Pain and lameness had been inconstant, recurring after intervals in which the child was apparently entirely well. General condition excellent. A diagnosis of hip disease had been made, in consultation with the family physician, on the above history, and the following signs which were observed October 25, 1900. Fullness of the left groin and flattening of left natis, the left giteal fold more shallow than the right, left thigh and leg ½ in. and ¼ in. less in circumference than the right and limitation of extreme motion in every direction with reflex muscular action. Limitation of motion was not found at the second examination but reappeared at a later date. On presentation the child walked when the splint was off with no defect in her gait. When she was examined slight limitation of motion and reflex spasm were found by different observers on attempting extreme flexion, extension, abduction, rotation and abduction with the thigh flexed at a right angle. An ischiatic crutch had been applied November 15, to be worn in the day time with a high sole on the well foot, directly to relieve the limb from the labor of locomotion and the affected bone from bearing the weight of the body, and ultimately to permit resolution of the inflammation by natural processes. Prognosis: absorption or incarceration of the focus in the cancellous tissue and recovery, after one year or two years, without deformity or any trace of disability.

Dr. Taylor and Dr. Myers recognized the presence of some of the signs of hip disease and thought that a positive diagnosis required further observation.

Dr. Gibney said that after the reported and present examinations he would give the patient the benefit of the doubt and consider the case as an incipient one and if changes occurred requiring more drastic measures he would seek very seriously to overcome the reflex spasm by immobilizing or putting the parts at rest. If the perineal crutch could be relied on to

give the hip rest enough so that the resolution would take place, however small the focus or wherever located, the treatment was perfectly justifiable. He appreciated the importance of protection from weight and concussion, but thought that an apparatus which allowed pressure of the toe on the ground did not give enough protection to the joints, so far as reflex muscular spasm was concerned. He questioned whether it did not add to the reflex spasm to have the patient stepping on the toe and ball of the foot.

Dr. Judson said that the ischiatic crutch as commonly worn allowed the anterior part of the foot to reach the ground. The toe could be entirely removed from the ground by using a longer crutch and a higher sole, but this would lessen the ability of the patient to walk. He thought there was an important difference between concussion transmitted from the heel through a straight bony column to the affected joint and the same modified in transmission by the interposition and action of the ankle joint controlled by the muscles of the calf.

Dr. Gibney thought that the protection of the joint was not so important as relief obtained by preventing reflex spasm.

Dr. Elliott questioned whether the form of apparatus worn by the patient was sufficient in a patient having a good deal of reflex spasm.

Dr. Taylor questioned whether in a case representing well marked symptoms it would not be better to apply a splint with adhesive plaster to be worn day and night than to use an ischiatic crutch to be removed at night.

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Dr. Judson said he had lost faith if he ever had any, in the effect of apparatus designed to elongate contracted muscles or to arrest or prevent reflex action by a direct mechanical pull. Indirectly these important objects were gained by arresting the functions of the diseased joint thus permitting abatement and resolution of the inflammatory action, which was the incitement of reflex muscular action. The latter ceased as soon as arrest of function brought about resolution. The two chief functions of the hip joint were motion and weight-bearing and that the latter, carbut the other advantages were obvious. It practically put the limb to bed and let the patient run about and go to school. In the painful periods of hip disease the tradition splint, combining the protection of the crutch with traction by adhesive plaster, was indespensable for the relief of pain by fixation.

CONVALESCENT WHITE SWELLING OF THE KNEE.

Dr. Judson presented a boy 7 years of age slowly convalescing under mechanical treatment for white swelling of the left knee. A year ago the patient's general condition was most unfavorable and locally there were sinuses surrounding the knee, great swelling and the usual evidences of a disintegrating joint. His condition and the method of his treatment

were described when he was presented to the Section on October 20, 1889, (See Alabama Medical and Surgical Age, Dec. 1889, XII pp 33-34.) and the opinion was expressed that it was a case in which operative surgery should be practised in order to save life. Continued reliance, however, had been placed on the reparative natural processes assisted by mechanical treatment. In spite of the most unfortunate and discouraging environment, improvement had been marked generally and locally. The tumor was very much reduced and firm scars had taken place of nearly all the sinuses. A yera ago the child was emaciated and distressed, but, on examination, he was found to be well-nourished and comfortable. Treatment would be continued by a fixative brace worn day and night and an ischiatic crutch worn only in the day time. Prognosis was still in favor of a useful limb, of good length, with no flexion and no deformity except a slight and unimportant degree of subluxation.

Dr. Elliott said that some of the swelling might be gotten rid of by systematic compression and drainage and removal of the tight band above the knee.

Dr. Judson said that the tumor of white swelling of the knee disappeared with the other signs and symptoms which yielded in due time to natural repair and restoration assisted by treatment. What appeared to be a tight band was that part of the fixative apparatus which made pressure from before backward near the joint in opposition to the counter-pressure made by the ends of the brace from behind forward at the extreme upper part of the thigh and lower part of the leg. There was no constriction or interference with circulation or nutrition at any point as no part of the brace was allowed to touch the posterior surface of the limb near the joint. The apparatus was a simple lever and any other arrangement of it would destroy the leverage which was relied on to arrest motion and reduce the flexion.

Dr. Taylor said that this result reminded him, by contrast, of the many patients he had seen with limbs disastrously shortened and deformed as the result of excision, an operation which interfered with the growing epiphyses, leading frequently to a shortening of 6 to 8 inches. He recalled an instance of this operation in which the result was complete dislocation of the tibia backwards and a flail joint.

Dr. Gibney said that the best surgical practice omitted excision of the knee in children. He saw too many patients coming for the correction of deformity and almost hopeless disability, the results of excision. To save life amputation was required, in certain cases, but never excision in a child. He advocated a country branch to a hospital, open the year round, where children could be on a farm and have simply nurses and a physician or two to look out for them and do very few operations.

Dr. Judson said that the admirable plan thus outlined was too pure-

ly expectant. He would add thorough and painstaking mechanical treatment which, no less than good food and wholesome surroundings reinforced the processes of recovery in growing children.

Dr. Myers said that general surgeons should agree with orthopaedic practitioners in interdicting excision of the knee in children. He had kept a boy under strict observation for 6 years after his knee had recovered to prevent excision for deformity until he attained his growth. He returned from a vacation, however, to find that the patient had been sent to a general hospital where excision had been done at once with recurrence of extreme flexion with lateral deviation and the certainty of more shortening with further growth.

CASES OF FUNNEL CHEST.

Dr. Taylor reported the case of a girl 6 years of age, seen in September, 1900, with remarkable congenital depression at the lower end of the sternum, an instance of typical funnel chest of moderate degree. There were no evidences of rickets and the child's health was good. She was the fifth child in a family of seven. Her mother had the same deformity, but knew of no other cases in the family. This condition was usually attended with some displacement of the heart but without impairment of circulation or respiration. Persons thus deformed has made fair athletes and soldiers.

FATAL CASE OF ABSCESS IN CERVICO-DORSAL POTT'S DISEASE.

Dr. Gibney exhibited specimen from patient affected with Pott's Disease with deformity. A girl 5 years of age had been treated as out-patient by a head support for 2½ years. The appearance of an abscess over the spinous processes of the last cervical and first and second dorsal vertebra made it difficult to adjust the support properly and the child became an in-patient. Aspiration gave only partial reduction of the tumor and a sinus was established by an incision after which the child was going about the ward with the head support comfortably readjusted. In the afternoon of November 8, 1900, cyanosis appeared, was relieved when the patient was put in bed but recurred during the night, when death seemed imminent. On November 9, a tumor was found in the outer portion of the left cervical triangle with deep fluctuation. Pressure did not increase the flow from the sinus but added to dyspnoea. Traction by the weight and pulley failed to give relief. Attempts at exploration of the pharynx increased cyanosis. Under ether (3 drams) an incision 2 in. in length along the sterno-cleido- mastoid exposed the carotid and a needle procured cheesy pus. With the finger between the carotid and oesophagus a second sac was ruptured with the evacuation of 4 ounces of pus and some bone detritus. A drainage tube was inserted. Respiration became easier. Temperature 104.4 degrees in the afternoon. November 10 and 11 the

patient slept fairly well at night but with a good deal of coughing and had reoccurrences of difficult breathing and cyanosis in the day time. The temperature fell to 100 degrees. After sleeping the early part of the night the patient died suddenly on November 12 at 3:30 a. m. Autopsy in the afternoon showed recent pleuritic adhesions with normal lungs and abdominal viscera. The two abscesses did not communicate with each other directly. Cavities in the vertebral bodies communicated with the sac of the second abscess which extended along the anterior and lateral aspects of the vertebrae and downwards behind the pleura and almost surrounded the oesophagus. The pleura cavity was not invaded. There had been no paralysis. The cord was found to be pretty good in consistency all the way up. He had seen no less than six children die unexpectedly in the night with abscesses arising in this location from carious vertebrae. Autopsies had not made clear the cause of death.

Dr. Myers referred to the case (related at the meeting of March 18, 1898,) of a boy 7 years of age affected with vertebra disease in this location, and an abscess discharging in the posterior triangle, whose temperature, on repeated trials, rose when the boy was up and fell when his lying down facilitated the drainage of the abscess.

AMENORRHEA, DYSMENORRHEA AND KINDRED DISORDERS.

Treated With Ergoapiol—(Smith.)

(Reprint from Obstetrics, June, 1900.

In the treatment of Amenorrhea, Dysmenorrhea, and kindred disorders, a practical experience of a number of years has convinced me that Ergoapiol (Smith) leads all other emmenagogues in points of efficiency, certainly in action, and rapidity of results.

Other remedies I have used I have found at least to be very uncertain in their action, and a few successive failures not only cause the physician to lose faith in the value of the preparation, but also cause the patient to lose confidence in the physician. In the use of Ergoapiol (Smith) I have yet to meet my first failure. The following cases will give an idea of its merits:

Case I.—M. G., age 19; had never menstruated, very anæmic, suffered irregularly from severe pains in the abdomen; local examination gave negative results. I prescribed one capsule of Ergoapiol (Smith) every four hours, and three days later menstruation began, and has been regular ever since.

Case II.—L. D., female, age 19; primipara; had not menstruated since confinement, a period of ten months; had tried various emmenagogues without results; consulted me April 27th last; was given Ergoapiol (Smith) in doses of one capsule three times a day. Menstrua-

tion began on the 30th; was absolutely painless and normal in every respect.

Case III.—M. J., age 22; unmarried; had suffered from dysmenorrhea for several years; had been treated by specialists, but received no benefit. Examination disclosed no displacement, stenosis, or structural cause. Patient was given Ergoapiol (Smith) four capsules daily, and has since had no return of the pain, and menstruates regularly.—Dr. W. A. Weightman, New York City.

HUTER McGUIRE'S OPINION.

The late Hunter McGuire, the most celebrated surgeon of his time in the United States, if not in the world, was asked for his opinion of antikamnia by Dr. Thos. C. Haley, of Riceville, Va. Dr. Haley in writing of this circumstance to the Antikamnia Chemical Company, says as follows:

"I recently wrote to Dr. McGuire and gave him my experience with antikamnia in my own case and that of others. Of myself, I said that I had been using the five grain tablets for four or five years consecutively, and always with great and signal relief to my sufferings. I vouched for it as being the grandest succedaneum for morphia. While I entertained these opinions personally, I still felt that the quantity taken should be justified by consultation. Hence the letter to Dr. McGuire and I am pleased to hand you herewith his reply."

The following is Dr. McGuire's reply:

St. Luke's Home, Richmond, Va., Nov. 8, 1894.

Thos. C. Haley, M. D.,

My Dear Doctor: I don't see any reason why you shouldn't continue to take the remedy (Antikamnia Tablets) of which you speak and which has done you so much good. I don't believe it will do you any harm. With kindest regards and best wishes, Very truly yours,

(Signed) Hunter McGuire.

Society Reports.

NEW YORK ACADEMY OF MEDICINE—SECTION ON ORTHOPAEDIC SURGERY.

Meeting of October 19, 1900.

Dr. H. Gibney read a paper on the Diagnosis of Pott's Disease. The paper was illustrated by the exhibition of photographs and the presentation of patients.

Case I.—Cervical Pott's Disease. Girl 8 years of age. Marked deformity from disease of long duration of several of the cervical vertebrae with scars of abscesses below the site of the disease. Treatment had been discontinued in the summer of 1900. The child had worn a head support combined at first with a plaster of Paris jacket, and afterwards with a Knight's spinal brace.

Pain near the seat of the disease, which is often absent in the other regions, is a common symptom in this region, with a sensitive area at the side of the neck, severe pain with voluntary motion of the head and neck and apparent torticollis yielding easily to traction applied in such a manner as to hold the head in its normal position. Before treatment, relief was sought by a supporting hand held under the chin. Abscesses are not an uncommon incident of cervical disease, detected by an examination of the posterior wall of the pharyux or burrowing under the superficial muscles of the neck.

Case II.—Cervical and Dorsal. Boy 5 years of age, affected for 2 1-2 years with disease extending from the middle cervical to the middle dorsal region. Two abscesses had opened spontaneously at the sides of the neck under the sterno-cleido-mastoid muscle. He had worn a plaster of Paris jacket and a jury-mast for 18 months.

A grunting noise with each expiration is almost characteristic of cases of the dorsal region and an early diagnosis is greatly assisted by the occurrence of gastralgia and the appearance of a careful gait and a peculiar apprehensive attitude, expressive of timidity and insecurity, and an instinctive desire to avoid disturbance of the diseased vertebrae. The first sign of a Kyphos is seen in a slight angle breaking the long

natural curve of the spinous processes observed in profile as the patient lies prone.

Case III. Tenth Dorsal. First stage. Girl 8 years of age. Under observation since May 5, 1900, and regarded for a time as a case of lateral curvature with a hyper-sensitive, almost neuralgic, condition of the spine. Very recently a suspicious point had been detected at the 10th dorsal and treatment would now be by a Knight's support.

Dr. T. H. Myers said that lateral curvature often attended incipient Pott's disease and obscured the nature of the more serious affection, as had occurred in the present instance. He thought that these doubtful cases should be considered as cases of the vertebrae until a positive diagnosis could be made.

Dr. H. S. Stokes said that in obscure cases of early Pott's disease the plaster of Paris jacket was valuable as a means of verifying the diagnosis. In cases in which there was at first no apparent deformity if the jacket were applied and left on for a time, then removed, the kyphosis, if present, would be seen at once. This effect was seen too soon to be due to further progress of the disease, nor could it be said that the jacket had caused the kyphosis. In a doubtful case, showing no deformity, he would apply the jacket as a diagnostic measure.

Dr. A. B. Judson said that similarly the tumor of white swelling of the knee became more obvious soon after the beginning of mechanical treatment probably from pressure and restraint applied to the soft parts.

Dr. Gibney resumed his presentation of patients as follows:

Case IV.—Dorso-Lumbar. Girl 2 1-2 years old, affected with disease of the dorso-lumbar region of 9 months' duration. No abscesses. The spine had the marked rigidity which attended disease in this region and marked gastralgia had been a part of the history of the case. A plaster of Paris jacket had been applied at first, but lately a recession of the deformity had been observed to follow the strict application of a Bradford frame.

Case V.—Eleventh Dorsal—Third Lumbar. Girl 13 years old, who had recently come from Russia with a very marked kyphos. But little had been learned of the history and treatment. Sinuses were discharging at points where abscesses had opened spontaneously. The gait and attitude were very characteristic of disease in this region. A Knight's support had been applied and as the child's general condition was fair, the prognosis was good.

Dr. Myers said that the characteristic attitudes of Pott's disease, although early and important signs, were also seen in osteitis of a syphilitic or malignant origin. It was, therefore, important to consider the personal and family history, the age, the location of the disease and the mode of onset as well as the pain and tenderness. The

fourth patient presented had been free from pain in the abdomen and legs. Pain in the terminations of the nerves was not so early or so prominent a symptom in the lumbar as in the dorsal region, while local tenderness was more apt to be recognized in the cervical region, where the affected parts could be more easily palpated than in the other spinal regions. In the cervical region the vertebral articulations might become infected by organisms gaining access from the pharynx after measles or scarlet fever with resulting muscular spasms and malpositions of the head simulating those of Pott's disease and it might be a long time before it could be decided that a post-pharyngeal abscess had its origin in vertebral caries. A long time might also elapse before it could be known that a traumatic osteitis in the cervical or lumbar region had become tubercular. There were absolutely no pathognomonic symptoms.

Dr. J. P. Fiske said that he had not as yet seen a case of traumatic spine go on to tubercular caries.

Dr. Judson said that Pott's disease presented some unexpected features, such as the occurrence of pain in the front of the trunk while the disease was in the back. Some patients also with serious and purulent destruction of bone maintained the appearance and general ability of robust health. This affection, justly compared with fracture of a central and most important part of the skeleton, was, as a rule, so free from local pain and disability that when these symptoms were persistent and exaggerated Pott's disease gave way to malignant disease of the vertebrae as a probable diagnosis.

Dr. Myers said that the diagnosis of the latter affection would be assisted by consulting the following clinical features: Rapid emaciation and loss of strength, every motion exquisitely painful, pain constant but motor paralysis less constant, marked muscular rigidity, kyphosis absent or late in its appearance, occurrence at any age.

Dr. Fiske said that as they all had deformity the presentation of these patients failed to throw light on the most important question, that of making an early diagnosis. Diagnosis before deformity was an extremely difficult thing, and proportionately important and desirable. Suspicious spinal symptoms might be produced by rheumatism, by neurotic reflexes, myositis following a blow or by some other and more obscure muscular lesion. He had seen cases in which circumcision had dissipated spinal symptoms which had been hard to interpret. Muscular spasm or spinal rigidity could not alone support a diagnosis of tuberculosis of the spine.

Dr. C. R. L. Putnam recalled the history of a case which he had observed in a foreign hospital.A man, 45 years of age, totally paraplegic, was thought to have disease of the first and second lumbar vertebrae

with a tubercular abscess pressing on the spinal cord. The removal of two laminae revealed the presence of an echinococcus cyst behind the theca. The result was unfavorable.

Dr. Myers had seen a tumor of the lower cervical produce not only symptoms of pressure on the cord, but also the local pain and muscular rigidity which usually attend vertebral disease.

Dr. F. A. Goodwin, of Susquehanna, Pa., said that railway brakemen, from their custom of jumping off and on trains in motion, frequently received spinal injuries accompanied by rigidity, pain on pressure and other symptoms of true Pott's disease. Perfect rest for a long time, however, almost always cleared up the diagnosis. It had been his misfortune to see a number of patients in whom the diagnosis of Pott's disease had been inexcusably postponed by eminent authorities. He instanced the history of a little boy who had been treated for asthma and other affections without an examination for kyphosis, which had existed to a marked degree for a long time during which grunting expiration, pain, inability to stoop and rigidity of the spine had been obvious features of the case. On the other hand, he had made a diagnosis of Pott's disease in a little girl who had a board-like rigidity of the spine. She could not stoop to pick up a coin from the floor without putting a hand on the knee for support. Her recovery without treatment was explicable by the supposition that there had been synovitis of the costo-vertebral and costo-transverse articulations. He thought that a diagnosis before the appearance of deformity was exceptional and recognized the inherent difficulties of the situation.

Dr. L. W. Ely referred to the opinion which prevailed among general practitioners that Pott's disease in the dorsal and lumbar regions was attended by sensitiveness to pressure on the spinous processes. Although this supposition was not unreasonable, in view of the nature of the lesion, the fact was that this symptom was of very rare occurrence. Running the fingers down the spinous processes in a doubtful case was of almost no value in making a diagnosis.

Dr. G. R. Elliot said that in a rapid carious process we had the full quota of symptoms clearly defined while a slow morbid action gave but few and obscure indications. The X-ray had been a disappointment in this field. It had failed to reveal a deposit before the appearance of deformity. What was desired was an early diagnosis, a diagnosis before deformity, which, of itself, made the diagnosis without the assistance of symptoms or any other signs. A most important early symptom was abdominal pain. How often are we told of the postponement of a spinal examination in favor of treatment for intestinal disturbance until an early diagnosis was impossible. A child should be examined with all the clothing removed. In no other way

could the obscure signs be recognized. The enlarged abdomen was another important early sign. The contraction of a psoas muscle exposing one to the risk of a faulty diagnosis of hip disease, might be the earliest sign of Pott's disease. He recalled the case of a child who was said to have cervical caries of two months' duration following scarlet fever with rheumatism. There was painful spasm of the muscles of the neck, the head resting on the shoulder and a hand supporting the chin. The symptoms all disappeared without fixation after treatment by simple suspension. On the other hand a patient with supposed rheumatism of the spine, whose symptoms included pain in the back, stiffness and misunderstood reflex spasm, was bathed, rubbed and shaken up for three months and, after vigorous anti-rheumatic treatment had lasted for a year, the appearance of kyphosis determined the diagnosis.

Dr. Gibney said that photographs clearly presented the attitudes, but failed to display the characteristic movements and deportment of the patient affected with Pott's disease. There was in his collection, however, one which graphically copied (see the accompanying figure) the over-erect attitude which was assumed by the patient's entire figure and threw light on the mechanism of the production of the lordosis which appeared as a compensating curve below the kyphos.

SWINDLER ARRESTED.

During the latter part of the past month, we received a letter from Dr. W. Peyre Porcher, of Charleston, S. C., in which he stated that a man personating himself, etc., had been victimizing many of the profession by pretending to be in distress, and borrowing money from them. The description given by Dr. Porcher for the apprehension of the swindler corresponds with that of a man named Wm. A. Ferguson, who was arrested in New York city November 26, 1900. It is claimed that this offender, who is described as being 59 years old, with heavy gray moustache, about 5 feet 8 inches tall, and of spare build, has for more than a year been victimizing physicians throughout the Eastern States. For some reason Ferguson was discharged by the magistrate of the court in which he was first tried November 28th, but he had hardly reached the street when he was re-arrested by a detective who will carry him to Washington, D. C., where, it is said, he is under indictment for swindling physicians, having pursued there the same methods he pursued in New York.—Va. Med. Semi-Weekly.

FRESH MATERIAL.

It is reported that the recent alarming increase in the prevalence of yellow fever in Havana is due largely to the presence in the city of many immigrants from Spain. During the past year 40,000 Spanish laborers have come to Cuba, seeking employment on the plantations. As a rule they soon found work, because the native does not hanker much for a chance to labor. However, all the time a large number of these susceptible immigrants are present in Havana, and the fever finds in them excellent soil for its spread. Precautions are now being employed to promptly forward these immigrants to the plantations, so as to reduce to the lowest available point the pabulum for the disease. A serious feature of the epidemic is seen in the number of deaths that have occurred away from the slums and the commonly-infected quarters. The Chief Commissary, Major Peterson, recently died of the disease, and his devoted wife an hour afterwards suicided. Major Valery Havard came down with the disease late in October.—Ex.